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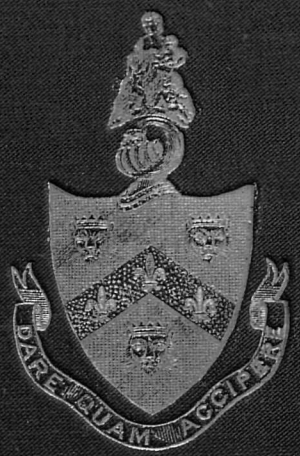

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Notice.

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Guy's Hospital Gazette,

JANUARY 12, 1895.

Non-Ulcerative Colitis.

TWO CLINICAL LECTURES BY DR. HALE WHITE.

LECTURE I.—SIMPLE COLITIS.

GENTLEMEN,—It so happens that we have now in John ward two striking cases, both of which we believe to be suffering from Simple Colitis; and as it is not often that such an opportunity of studying the disease presents itself, I think we cannot do better than go over the subject.

The first patient is a man aged 30, who on the morning of December 26th had an attack of diarrhœa, and passed, we are told, motions consisting of nothing but mucus, with probably some blood. The call to relieve the bowels was very urgent; towards evening the motions began to contain fluid matter. The next day, in spite of bismuth and morphia, the diarrhœa continued, and he had a dull pain in the rectum. December 28th, he was much the same, excepting that there was more abdominal pain, which was only present with the diarrhœa. December 29th, he had to go to bed; his temperature was 100. December 30th, the griping abdominal pain, which began in the right iliac fossa and worked all along the colon, was very marked; temperature 102·2. On December 31st he came into the Hospital, looking ill and anxious. He lay on his back, and said the jolting of the cab hurt him. There was tenderness all over the abdomen, especially along the line of the colon. There was no constant pain, but he had occasional sharp attacks. His appetite was poor; his tongue was coated with a white fur; his temperature was 104·2. He was made to keep quiet in bed, and the abdomen was well wrapped up; he was allowed some milk. No opiate was given as the diarrhœa was stopping, and the constipation after colitis is often a great bother. He is now convalescent, but we have not let him sit up, as his abdomen is still tender along the colon.

The next case is that of a man, aged 38, sent up by Dr. Cobham Payne, of Witham. He was quite well till twelve weeks ago, when he was suddenly taken with diarrhœa, the bowels being open five or six times a day, and the motions containing at first little but mucus and blood. When the bowels were open he often had much griping pain. In spite of these symptoms, and the fact that he has lost twenty pounds in weight, he has kept on at his work as a baker.

On admission, there is tenderness over the transverse and descending colon and sigmoid flexure. No tumour can be felt. The mucous membrane of the rectum, which is a little ballooned, feels rough. There are no piles. A motion that he passed contained some blood and mucus. Under the microscope there were quantities of leucocytes, red blood-cells and triple phosphate crystals. You see before you a similar motion passed this morning. His tongue is covered with a white fur, except at the edges and tip.

He was put to bed and given milk, and all his symptoms improved. The bowels are now open only once a day, and tenderness is present only over the sigmoid.

The diagnosis made in these two cases was that of primary acute colitis. I say primary because there is a variety of colitis, of which we will speak presently, which occurs as a complication of other serious conditions, such as pneumonia, Bright's disease, etc.

Now, you may fairly say to me, What is your evidence that such a disease exists? Well, I

think I can quote to you convincing evidence. You well remember that, last November, there was a man in Stephen ward who was anæmic, wasted, extremly neurotic, depressed and melancholy. He gave a history of having been sick, he had abdominal tenderness, some thirst, and passed much blood and mucus from the bowel. There was some doubt as to whether an ulcer could be felt high up in the rectum, so he was examined under an anæsthetic with a speculum. As far up as could be seen, the mucous membrane was very injected and covered with an excess of mucus, so there was every probability that the colon was also affected. Then, you will remember that the mucous membrane felt rough in the second of the two cases we are discussing to-day. Many of you have read, and all of you must read, your Wilks and Moxon, for no other book on pathology can give you that wide acquaintance you get from it. You will find there described "a case attended by discharge of mucus and blood, where, after death, the whole internal surface of the colon presented a highly vascular soft red surface, covered with tenacious mucus or adherent lymph, and here and there showing a few minute points of ulceration; the coats also were much swollen by exudation into the mucous and submucous tissues." A very typical case was under Dr. Perry, in 1891: the patient was a woman in her seventh month of pregnancy; she was evidently very ill, and died three days after admission; for the last four hours of her life she had diarrhœa. The whole colon was inflamed, the mucous membrane being thick, sodden, and deep purple; there was no ulceration and no membranous exudation. The liver was fatty.

I have seen one fatal case myself, but, unfortunately, no post-mortem examination could be obtained. The patient, a lady, aged 30, had diarrhœa for two weeks, but kept about her usual round of shopping and household duties. As she got no better she called in Dr. Jolly. He put her to bed and gave her opium. The bowels were then open about four times a day. The motions contained much mucus and blood; she had very little pain, but was sick at times. When I saw her, with Dr. Jolly, a week later, the temperature was 101; the tongue had a white fur; the motions, which were very frequent, contained much mucus and blood—some clotted, some unclotted. She was excessively exhausted and anæmic, and, although by full use of opium we controlled the diarrhœa somewhat, we could not save the patient, and she died three days later. Her temperature shortly before death was 102.

I think that now you will have a clear idea of the morbid anatomy of colitis, the chief points being the intense congestion, so that the colon is red or even livid; the submucous tissue is swollen; the surface of the mucous membrane is rough—it may have some recent adherent lymph on it—and occasionally there are some minute, quite superficial ulcers. The liver may be fatty.

Let us now pass on to the symptoms of a severe case. The most important is diarrhœa; the bowels may be open many times a day and the motions may consist of nothing but mucus and blood, which is usually but little changed, and is not intimately mixed with the rest of the motion. These facts show that it has not long left the blood vessels, and has, therefore, come from the large intestine rather than the small. The quantity of blood passed may be very great. In certain rare cases the motions are frothy, as though they had undergone gaseous decomposition. Under the microscope you see crowds of leucocytes, unaltered blood cells, and various crystals, chiefly triple phosphate. When the case improves, or in a mild case, there is more or less fæcal matter in the motion. The calls to stool may be often repeated, and then the motions are small. Tenesmus may be present, but frequently it is not a striking feature. A rectal examination usually reveals nothing abnormal, although in one of our cases the mucous membrane felt rough.

Abdominal pain is a very common symptom. It comes on in paroxysms often associated with the act of defæcation, but bearing no relation to food. It is a griping pain, frequently distinctly following the course of the colon. In between the paroxysms the patient is usually free, but there may be dull abdominal pain. Sometimes pain is almost entirely absent, but, on the other hand, the paroxysms may be very severe. Abdominal tenderness is usually present; a very common seat for it is over the sigmoid flexure, but the whole colon, or even the whole abdomen may be tender.

There is usually some pyrexia, often considerable, even when the patient is much collapsed from diarrhœa and loss of blood. The rapidity of the pulse is increased, and its characters vary according to the intensity of the attack. The abdomen is not held still, as in peritonitis, nor have I noticed much distension. Flatus may be passed from time to time, but this is not usually a very marked symptom. Some patients are sick, but vomiting is more often absent than present. The tongue is covered with a white fur; if any part is free, the edge

and tip are unaffected. There may be considerable thirst, and there is usually loss of appetite. Symptoms of irritability of the bladder are sometimes seen, and the patient may complain of dysmenorrhœa. The sufferers from this disease lose flesh considerably if the diarrhœa lasts some time and they are weak and anæmic. Not uncommonly, as, for instance, was the case with the man in Stephen, they are of a depressed neurotic turn of mind, inclined to exaggerate the importance of trifles. During convalescence, constipation is often a great difficulty. As with most diseases, cases vary much in intensity, some are mild and transient so that the patient does not call in a doctor, others are, as we have seen, fatal.

The diagnosis is not as a rule difficult. Acute dysentery is hardly ever seen in this country, and colitis does not show the meat washing stools so characteristic of it, nor are burning pain, tenesmus, and a constant desire to go to stool nearly so marked as in acute dysentery. Ulcerative colitis does not begin so acutely as simple colitis; the motions contain little or no mucus, and early in the case, at any rate, very little blood. The patient soon becomes very weak and anæmic, recovery is very rare, and treatment has hardly any influence on the course of the disease. The character of the motions, the sudden onset of the diarrhœa, the tongue, and many other symptoms sufficiently distinguish colitis from typhoid fever.

You will notice that for a correct diagnosis it is absolutely essential that you should examine the motions.

Lastly, never forget, in any case in which for some time blood has been passed per rectum, to think of the possibility of growth.

If you will remember the lecture given on ulcerative colitis last year you will easily see that simple colitis is a disease quite distinct from it, not only in its whole clinical aspect, but also in its morbid anatomy.

By far the most important part of the treatment is to get the case in hand early in the course of the disease, and put him to bed at once; in fact, persons with any but the very mildest diarrhœa, whatever may be its cause, should always remain in bed, and even if the attack seems quite trivial, it is advisable to go to bed early and not to get up till sometime after breakfast.

Another essential for any form of diarrhœa is warmth; a thick flannel binder round the abdomen is very useful. Milk is the best diet, only a little of that should be given; in a moderate case of colitis a pint in the twenty-four hours is quite enough for an adult, and he should not drink more than a sherry-glass-full at a time. If the pain and diarrhœa are sufficient to call for treatment, a mixture containing bismuth and morphia is often very useful, and if that fails, a starch and opium enema will usually succeed; but all treatment directed to stopping the diarrhœa should as soon as possible be discontinued, because the subsequent constipation is often troublesome. This may require a rectal injection of six or eight ounces of warm olive oil, or a drachm of glycerine. If for any reason you do not like to give opium, you will find the compound catechu powder very useful. Should the hæmorrhage be very severe you may use rectal injections of cold water, or you may pack the rectum with crushed ice, or what is probably best of all, you may inject, as high up as possible, a mixture of equal parts of Liquor Ferri Perchloridi and water. The hips should be elevated and a long rectal tube should be used. Your patient must never get up while his temperature is above normal, nor while he has any pain or diarrhœa. If they have been severe he must remain in bed some time after both have stopped. There are few things more important in medicine than when confronted with a case of diarrhœa to remember the words—Bed, Milk, Warmth.

I should now like to call your attention to what may be called secondary colitis. The following varieties of this exist:—

(1) It may be due to direct extension. I, some years ago, made a post-mortem examination on a woman who had swallowed a large quantity of sulphuric acid. All along the great curvature the whole thickness of the stomach was gangrenous, and the transverse colon, which was in contact with it, was red and black on its exterior and acutely inflamed on its inner surface.

(2) It may be due to direct irritation. Here is a specimen from our museum: it is the colon of a man who, in 1827, died of diarrhœa apparently due to overdoses of purgatives given to overcome obstinate constipation. The colon is black, gangrenous and sloughy. You know also that the large intestines may be inflamed in arsenical poisoning even when the small intestine is not affected.

(3) There is a form of colitis associated with septic or pyæmic processes. During the last few years the following instances of this have occurred in the Guy's post-mortem room. A woman died with chronic cystitis and suppurative pyelitis. She was found to have "rather intense colitis, the mucous membrane being rough, granular and ecchymosed." A girl, who

was extensively burnt, died, and there was pus in the right knee, and early acute colitis. About the same time, much the same state of colon was found in a girl who died from cancrum oris. A boy developed pyæmia, with pus in many joints, after a compound comminuted fracture. Nearly the whole of the colon was acutely inflamed; it was covered here and there with patches of yellow lymph, or slough, or minute superficial ulcers. A very extreme case was that of a woman with pelvic abscesses after gonorrhœa; the mucous membrane of the cæcum and part of the ascending colon was sloughing; that of the rest of the large intestine was very acutely inflamed.

(4) Acute colitis sometimes occurs in association with Bright's disease. It is a very rare association, but we have had some instances during the last ten years; for example, a man with chronic Bright's disease, for the last few days of his life, passed much mucus. At the post-mortem the whole of his colon was found to be inflamed. Acute inflammation of the descending colon was found also in a man aged thirty-one, who had gout and granular kidneys. Our museum contains three specimens of acute colitis in Bright's disease. I show them to you here. Sometimes the colitis of Bright's disease is associated with enteritis, as in a case recorded by Dr. Goodhart, in the Pathological Society's Transactions, vol. xxxvi.

(5) Pneumonia is, in extremely rare cases, associated with colitis. I can show you two instances of this from our museum. In both the whole of the large intestine was in a state of acute inflammation. Both had diarrhœa. As we know that the pneumococcus may be present in the pus of an empyæma, in that of the purulent pericarditis, or on the valves of the heart in malignant endocarditis when any of these sequelæ follow pneumonia, it is quite possible that it is the cause of the colitis.

(6) If the colon is lardaceous it may, like the rest of the bowel affected with lardaceous disease, become the seat of an acute inflammation.

Most of these cases of secondary colitis had some diarrhœa, the motions containing mucus, and probably blood; but, as persons suffering from Bright's disease, pyæmia or lardaceous disease often have diarrhœa, but little attention was directed to it, and we may, I think, say that secondary acute colitis is very rarely, if ever, diagnosed during life.

[*The second lecture will appear in our next issue.*]

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MAY	4, 9, 30, 41, 42.	Chlorosis.
	18.	Mitral stenosis.
	27.	Mitral stenosis and regurgitation.
	49.	Mitral regurgitation.
PHILIP	2.	Mitral regurgitation.
	25.	Mitral stenosis and regurgitation.
STEPHEN	1.	Mitral regurgitation.
	13.	Aortic stenosis.
	15.	Aortic and mitral regurgitation.
	32.	Mitral regurgitation. Pleuritic effusion.

Nervous System.

MARY	1, 24, 26.	Exophthalmic Goitre.
	3.	Chorea. Mitral regurgitation.
	19.	Chorea.
	29.	Friedreich's disease.
	39, 45.	Locomotor ataxy.
	43.	Hysterical paraplegia.
PHILIP	3.	Cerebral tumour.
	5.	Malarial neuritis.
	15.	Fits. ? Cerebellar tumour.
	30.	Double facial paralysis.
	36.	Syphilitic myelitis.
STEPHEN	13.	Cerebral tumour.
	17.	Chronic myelitis.
	36.	Aphasia. Cerebral hæmorrhage.

Alimentary System and Abdomen.

MAY	5, 16.	Gastric ulcer.
	13.	Tuberculous peritonitis.
	14.	Carcinoma of stomach.
	17.	Chronic gastritis.
	38.	Stricture of œsophagus.
PHILIP	15.	Gall-stones. Jaundice.
	18.	Jaundice. Malignant disease of liver.
	24.	Ascites. Cirrhosis of liver.
STEPHEN	10.	Ascites. Enlarged spleen. Gout.
	22.	Jaundice. Carcinoma of liver.

Typhoid Fever.

MARY	2, 8, 20, 21, 31, 32, 44, 47, 50.
PHILIP	7, 9, 21, 37.
STEPHEN	2, 19, 24.

Genito-Urinary System.

MARY	6, 10.	Chronic tubal nephritis.
	22.	Chronic interstitial nephritis. Hypertrophied and dilated heart.
PHILIP	11, 21, 28.	Diabetes mellitus.
	13, 40.	Chronic tubal nephritis.

STEPHEN 11. Diabetes mellitus.
18, 35. Chronic tubal nephritis.

Respiratory System.

MARY 36. Left pleuritic effusion.
PHILIP 1. Left pleuritic effusion.
6, 20, 23, 35. Bronchitis.
STEPHEN 7, 37. Bronchitis.

Phthisis.

MARY 15.
PHILIP 12.
STEPHEN 4, 25.

Miscellaneous.

MARY 23, 48. Acute rheumatism.
28. Pyrexia. ? Cause.
46. Acute rheumatism. Mitral regurgitation.
PHILIP 29. Acute rheumatism.
34. Tertiary syphilis.
STEPHEN 6. Gonorrhœal rheumatism.
8. Tuberculous joints.

CASES UNDER DR. PYE-SMITH.

MARY.

29. E.B., æt. 16. Admitted December 11th for weakness of legs. Patient has several brothers and sisters, all of whom are perfectly healthy, and of rather more than ordinary intelligence. Her mother had chorea when thirteen years of age; otherwise has always been very healthy.

When patient was a year old she was noticed to be weaker on her legs than other children. She says herself that she has never been able to walk quite well; that she used to tumble about and drop things she was carrying a great deal. Two years ago she lost control of her muscles to a great extent, and her legs became much weaker. Her grandmother has noticed no change in her speech.

On admission.—Patient is a rather pale girl, with a fairly intelligent expression. When sitting allows shoulders to droop: if tired or nervous is unable to sit still, but sways from side to side. *Speech* is rather slow and monotonous, but there is no slurring of syllables and no stammering. *Gait*, clumsy and slipshod; takes short steps, does not raise her knees, and drags her toes; if not nervous, can keep a straight course. If walking under observation she sways about a good deal, swinging one leg in front of the other, while her steps become quicker, and she makes for support; cannot stand with feet together and eyes closed.

Eyes.—Pupils react to light and accommodation. Sight good. No optic neuritis. The movements are good and regular, but if deviated much to right or left, and especially downwards, there is nystagmus, which is slow and only takes place when the eye is fixed on an object.

Sensory powers are perfect.

Co-ordination.—Cannot touch tip of her nose with eyes shut, but touches first the side and then runs finger up to tip. Similarly cannot bring tip of one forefinger into contact with the other directly,

Motor.—Power in both legs good, and there is no marked wasting. Grasp of both hands is 30 with Dynamometer.

Reflexes.—Knee-jerks absent; also elbow and wrist jerks. Plantar reflex dimished. Bladder and rectum normal.

Electrical reactions.—*Galvanic current*, all muscles react readily. *Faradic current*, contractions obtained everywhere, both with KCC and ACC, and in every case KCC > ACC.

Feet.—The arches of both are abnormally marked; the balls of the great toes are prominent, proximal joints are a little over-extended and the distal flexed.

PHILIP.

30. A. C., æt. 24. Admitted on December 3rd, 1894, for double facial paralysis, total deafness, and slight ataxia.

Previous history.—Patient comes of a healthy family; as a boy he worked in Glasgow, then for five years as a labourer in East London. Three years ago he enlisted and went to India. He was invalided out of the army and returned home in November, 1894. When in London he was pretty steady, but used sometimes to get drunk. Patient had gonorrhœa before he went to India. He had syphilis in Calcutta two and a half years ago; and has had four attacks of fever.

Present complaint dates from the last attack of fever, which occurred nine months ago and lasted three months. It is described as "enteric, followed by slow continuous fever." During this time his head began to swell at the sides; the swelling spread forward and involved the face, lasting altogether about four months; at the same time patient became deaf; he lost power over his facial muscles, and was unable to walk on account of a feeling of giddiness. During the last few months he has become stronger, and the giddiness has decreased so that he can now walk alone, but the paralysis and deafness remain unaltered.

On admission.—*Nervous system.*—There is complete paralysis of the facial muscles, the occipito-frontalis and platysma; the eyelids are always separated by at least a quarter of an inch; the lower lip hangs forward and the mouth cannot be closed; no expression can be given to the face; the buccinator being paralysed, food collects between the cheek and gums. Tested with the electric current the facial nerves were not irritable, the facial muscles gave an incomplete reaction of degeneration. There is no paralysis of any other muscles; those of the palate, eye, and tongue are quite unaffected. Patient's gait is unsteady; after two or three steps he gives a roll to one side and sometimes crosses his feet. When blindfolded and told to stand with his feet together he sways about, and must separate his feet to keep from falling. Cutaneous sensation, and muscular sense normal.

Cutaneous reflexes well marked; knee-jerks brisk, no ankle clonus.

Special Senses.—Total deafness, accompanied by occasional ringing in the ears, and giddiness. Smell impaired; camphor was said to have no smell, lavender was detected. Taste impaired; salt and vinegar recognised, sugar solution tasted "like water," quinine solution like "salt water" or "sweetened water."

Alimentary System.—Mouth dry, saliva acid. Since the onset of the facial paralysis, saliva has become scanty and viscid, and patient complains of thirst. Liver can be felt one inch below costal margin. Spleen enlarged, not tender.

Respiratory and circulatory systems normal.

Diagnosis.—? Syphilitic basal meningitis; ? syphilitic degeneration of nuclei of facial and auditory nerves on both sides.

CASE UNDER DR. TAYLOR.

STEPHEN.

9. G. W., æt. 47, a carpenter. Admitted for heart trouble and general weakness. He had pleurisy eighteen years ago, and was ill twelve weeks. He does not recollect being tapped. About seven weeks ago patient began to cough, and felt depressed. He was recommended to go into a hospital by the doctor who attended him.

On examination, the following conditions were found:—The left side of the chest moves very slightly in respiration; the whole of this side, both in front and behind, is dull; the dulness extends to the right of the sternum for about an inch. No breath or adventitious sounds can be heard except at the first space, where there is bronchial breathing; the right side is normal. In the sixth left space there is a well marked pulsation; in the second, third, and fourth right spaces systolic pulsation can be seen; there is also epigastric pulsation, and detraction of the third and fourth left spaces. A systolic bruit is heard in the aortic area, and the second sound is very loud. The pupils are equal and react normally; there is no difference in the radial pulses. Patient has no pain, and is quite comfortable.

January 5th. It was noticed to-day that the cardiac impulse was in the fifth left space just internal to the left nipple line; the pulsations mentioned above had not changed in character.

The condition of the left side of the chest is probably due to thickened pleura and fibroid lung, a sequela of the pleurisy eighteen years ago. The heart is evidently much hypertrophied, and the cause is far from obvious. The question of aneurysm is discussed, but there are no definite signs of this; the pulsation to the right of the sternum, however, suggests it.

The increase of cardiac dulness to the right may possibly be due to considerable hypertrophy of the right ventricle, secondary to the changes in the left lung. Another suggestion is hypertrophy of the heart, adherent pericardium. He is a case well worth going to see.

CASE UNDER DR. GOODHART.

PHILIP.

9. E. W. A., a S.E.R. porter, æt. 20. Admitted December 7th, having fainted at his work that morning. Family history was unimportant. He had measles in 1887, and "a chill on his kidneys" in 1892. Very moderate in alcohol.

He gave a history of a fortnight's cold, with consequent loss of taste. On December 6th he fell in the fog, and was shaken, some coals (about ½-cwt.) he was carrying falling on him; the same evening he had pain in back and stiffness in legs and knees; at night headache came on with increasing severity, and was accompanied, on waking, by dizziness. The next morning he fainted at his work, and, falling, cut his left eyebrow; he did not foam at the mouth, micturate involuntarily, or bite his tongue.

On admission.—Temperature, 102; respiration, 24. He sweats profusely and shivers all over; answers questions easily and willingly; no sign of cranial fracture; has severe, not localised, headache; also pain over sacrum, shooting up back. Nothing abnormal in circulatory, central, nervous or respiratory systems; eyes normal; tongue clean. His reflexes were rather brisk. There is hyperæsthesia over the sacrum. Frontal and spinal icebags were ordered. Mist. Amm. Acet. 4tis horis was, after two days, altered to Mist. Phenezoni 3tis horis, as his temperature had risen to 105 at 6 p.m. *Urine* normal. Bowels confined.

9th. Temperature, which fell yesterday to about 102, has risen to 103·3; he required morphia subcutaneously to get sleep; headache less severe; pain in back unaltered; patient has a short, dry cough, without expectoration; there are no signs of lung trouble, and no rashes anywhere. *Urine* contains a copper-reducing body.

10th. Omit icebags. Quinin. Sulph. gr. ij. Mist. Quinnæ ʒj. t.d.s. Purges were ordered, as bowels have not yet acted; he still perspires freely. Temperature is 99·8, headache is better, and pain and stiffness of knees have disappeared.

11th. Pains and headache almost gone; temperature subnormal; he is very drowsy and wishes to sleep. Appetite improving. Urine again contains the copper-reducing body, which, by fermentation and phenylhydrazine tests, was found not to be sugar. B.O. well twice.

14th. Temperature has remained down; pains and headache gone. For the last three days he has brought up a thick mucoid sputum. Bowels regular, urine does not reduce copper.

20th. Temperature remains down; he is now practically well, and went out to-day.

A curious point, having no connection with the illness, was the presence of what feels and looks like a fairly-developed left mammæ, size that of a girl of 13; there were no enlarged veins over it, skin does not wrinkle; it is uniform, and no cysts can be felt in it; axillary glands normal. Patient says one brother has a similar lump.

Dr. Goodhart, seeing patient on the afternoon of admission, said he was evidently suffering from an acute febrile attack, possibly typhoid, pneumonia, variola, scarlet fever, rheumatic fever or influenza. The profuse sweating was against typhoid; absence of lung trouble put out pneumonia; the pains, being not actually in joints, excluded rheumatic fever. Later, as no rashes appeared, scarlet fever and variola were impossible; and Dr. Goodhart confirmed the diagnosis which he had thought most probable on his first visit. He thought the mode of onset, form of pyrexia, pains and perspirations were fairly conclusive.

In the Surgical Wards.

CASE UNDER MR. HOWSE.

CHARITY 14. Varicose veins. Phlebitis.

CASES UNDER MR. DAVIES-COLLEY.

LYDIA 6. Lupus of face.
8. Ankylosis of knee in faulty position, following tubercular disease.
18. Strangulated femoral hernia.

CASES UNDER MR. LUCAS.

ACCIDENT 1. Compound fracture tibia and fibula.
7. Compound comminuted fracture tibia and fibula. Amputation.
11. Compound fracture tibia and fibula.
14. Compound fracture tibia and fibula. Fractured femur.

CHARITY 4. Strangulated femoral hernia.
Cot. Strangulated inguinal hernia.
Cot. Congenital hernia (funicular).

JOB 2. Nævus in cheek.
21. Mastoid abscess.
25. Perforating ulcers in feet.

CASES UNDER MR. GOLDING-BIRD.

LAZARUS 5. Epileptic fits following blow on head. Previously trephined without benefit.
7. Necrosis of lower jaw.
8. Mastoid abscess.

MARTHA 5. Tumour in scar in abdominal wall, results of ovariotomy.
7. Acute mastitis.
18. Tumour in breast. Chronic abscess.

From the Throat Department.

CASE I.—W. J. B., 39, circular sawyer, came up for "hoarseness," October 26th, 1894. Four or five months before, sudden hoarseness; cough. Dr. Shaw saw patient. No physical signs in chest; no history of syphilis; no enlarged glands; no sweating at night; appetite good; not losing flesh; father and brother $\phi\theta$.

Examination.—Epiglottis normal; fauces and tongue show no indication of old ulceration. The first view of larynx shows two large reddish masses—the left larger and slightly projecting past middle line—being the mucous membrane over the arytenoids. The left ventricular band is swollen, and obstructs any view of left cord. A good-sized ulcer running transversely across the false cord is partially hidden by the swollen membrane over arytenoid (left). There is less swelling of right ventricular band, so that the right cord can be seen to be hyperæmic and rounded. The case was shown at the Laryngological Society, and the concensus of opinion confirmed the original diagnosis of *tubercular laryngitis*. The ulcer was curetted, and lactic acid applied, ten per cent. to start with. Portions of the material removed showed no bacilli. Sputum not examined yet.

The case is interesting, presenting as it does certain features which might easily lead to a diagnosis of *syphilitic perichondritis* or *epithelioma*, and besides solving the vexed question of *primary laryngeal tuberculosis*. Space obviously will not permit of discussion on the diagnosis. Patient attending now.

CASE II.—W. B., 48, bootmaker, came up 9th November, 1894, for hoarseness, pain on swallowing and speaking. Three months' history; getting worse lately; cough four months; wasted a good deal; sweating at night; no physical signs in chest; no history of phthisis; never had syphilis.

Examination.—Fauces and pharynx extremely irritable. Ten per cent. Sol. Cocaine sprayed. Epiglottis much swollen and intensely red, with two sharply-defined ulcers on the commencement of the right glosso-epiglottic fold. Much sticky mucus about the larynx; swelling over left arytenoid and left false cord, allowing only the smallest line of the true cord to be seen. Right cord visible in its posterior three-quarter. At its most posterior part a somewhat excavated ulcer can be seen. Some swelling over right arytenoid, although not so much as over left. Movement of left cord seems impaired. The swollen condition of the epiglottis obscures the anterior commissure. The man is pale, thin, and looks ill, but after being on Ol. Morrhuæ, and using an inhalation, expresses himself relieved. Diagnosis, tubercular (?). Is attending now.

A. L. R.

MEDICAL MEN IN NEW SOUTH WALES.—In the cities and larger townships of the colony there is no lack of competent medical men, but in the newer and more remote districts they are too often conspicuous by their absence, and it is by no means unusual for the inhabitants of such places to advertise their willingness to guarantee a certain amount of income to a resident doctor. An experienced medical man, willing to "rough it" for a few years, will attain a competency much more rapidly than in England, especially if devoted to his profession, and skilled in the treatment of complicated cases. Medical specialists possess a wide field in Australia, where institutions for the treatment of eye and ear diseases, etc., are practically unknown.

The Festivities at Guy's.

(Continued).

THE Christmas-Tree in MARTHA, which we have almost begun to look forward to as an annual event at Guy's, passed off in the pleasantest way on the 28th ultimo. All the children who were able to be moved, were conveyed by the willing hands of the nurses and dressers into the ward about four o'clock, and assembled on the beds, chairs and the floor at the corner of the L where the tree had been previously decked—by Sister Martha and her band of helpers—with the usual ornaments and a large number of gifts, which had been provided for the youngsters, chiefly through the generosity of Mr. Golding-Bird. Proceedings began with a concert, to which the following, amongst others, contributed—Messrs. Poole, Hicks, Michael, Scott-Turner, Thomas and Hancock, and Misses Burge, Collier, and other ladies whose names did not transpire.

The ever-welcome tea was then served, while "Father Christmas"—who was ably personated by Mr. Golding-Bird's House-Surgeon, Mr. Poole—was "made up," and the tree was brightly illuminated with the tiny many-coloured candles so indispensable to the success of the function. Amidst the excited cheers of the children, Father Christmas made his appearance at the lower end of the ward, labouring along under a huge sack of toys. A few kindly and well chosen words of greeting, and "Daddy" commenced the arduous work set for him, in distributing the gifts and toys of every description, which had been allotted to almost every one present. These gifts numbered close upon 300, and their distribution proceeded merrily enough, not only the children and out-patients, but also the Sisters, nurses, dressers, ward clerks, and visitors being included among the happy recipients. Many of the gifts were made artfully appropriate to the idiosyncrasies of the older folks, and no small amount of amusement was got out of them.

Towards seven, the proceedings, which had been carried on throughout with great spirit, came to an end, and the happy faces of the children as they departed, unmistakably showed their keen appreciation of the strenuous efforts made to give them pleasure. Sister Martha, and the others responsible for the happy afternoon so thoroughly enjoyed by those who were fortunate enough to be present, are to be congratulated on the success of their undertaking.

Long before the last day of the Old Year, the occasion of the concert in PHILIP, excitement had been roused to fever heat by the rumour that several of the most prominent singers in comic opera had consented to appear; in this case rumour was but another name for fact, although at the last moment some of those who promised their services to Dr. Bryant, the promoter, were prevented from coming—Miss Gracie Whitford, through illness, and Miss Florence St. John, and Messrs. J. L. Shine and Arthur Playfair, from other regrettable causes. However, who could complain when Messrs. E. J. Lonnen, John Sheridan, and John Le Hay were to entertain us. Philip, tastefully decorated, was well filled. Mrs. Allworth and party, the Misses Carter, Dr. and Mrs. Shaw, Mr. and Mrs. Lane, and most of the Sisters, were amongst those present when Miss Allworth, in a tuneful pianoforte solo, gave us a first promise of the good things to come. Then Miss Ethel Edwards sang very pleasantly "The Orange Garden," from "Little Christopher Columbus," and Mr. Owen Harris followed with a thrilling recitation, "The Rescue," which, however, happily ended well. When Miss Kershaw's "Because" had been well received, Mr. E. J. Lonnen provoked roars of laughter with the ditty, "That Awful Little Scrub," and, as a well-merited encore, obliged with a humorous recitation. Mr. Ford Featherstone now told us of his first and only appearance in amateur theatricals, and Mr. Robb Harwood warbled "The Story of a Kiss" to the general delight; after which came one of the plums of the entertainment in Mr. John Sheridan's "Dennis Brady's Cat," he answering a universal encore with "The Maiden and the Lamb." "When Bright Eyes Glance" was the contribution of Mr. Constanduros, whose fine mellow voice was well suited to such a concert-room; and the first portion of the programme was brought to a close by Mr. H. Harden with the ditty, which has before pleased us so much at a Guy's smoker, of the odd pair of lovers who never were wed; it will be praise enough to say that the song had lost none of its old charm.

Tea, coffee and accompanying delicacies having been freely partaken of, Miss Kershaw commanded silence for the second part, with a charming song, more suitable to her voice than the previous effort. Miss Ethel Edward's "Marguerite" deserved even more applause than it evoked, which fact was, perhaps, due to the collapse of the audience, occasioned by the preceding item—Mr. Le Hay's Ventriloquial Sketch—(the extreme merriment provoked by it has not, we are glad to hear, been followed by any serious casualties; the anecdote of the drowned fowls should be a sufficient warning to those of us who keep pets to suit the variety of the hygienic conditions of the establishment). "Soosie Toosie" is always a favourite, and Mr. Robert Harwood's rendering was deservedly popular, followed by the "Skipper" of Mr. Constanduros, which was splendidly given. After Mr. Harden had again charmed us with his "Mermaid and the Bosun"—vieing in effect with his first ballad, Miss Kershaw, with a third tastefully-rendered song, brought to a conclusion one of the finest as well as most entertaining performances ever heard within our walls.

The occasion must not pass without many thanks to Dr. Jackson Lang for the trouble he took in getting the performers together, and to Miss Allworth and Mr. Ernest Bucalossi for their able accompaniments, to which some measure of the success of the singers was no doubt due.

On New Year's Eve a delightful concert was given in JOB, before a large and most appreciative gathering. The programme was an excellent one, and the credit of its careful arrangement is entirely due to Mr. Spon. No small amount of the success of the evening was because of the varied nature of the proceedings. After Miss Spon had opened the ball with a selection from "Faust," Mr. Constanduros, whom we had already learnt to appreciate in the afternoon in Philip, sang "The Skipper," and in the second part of the programme kindly contributed "When Bright Eyes Glance," both of which made a great impression. Miss Mabel Senior charmed everybody with her singing, and "Hush-a-bye," with guitar accompaniment, followed by "Diddle-oddle-chip-cham, etc.," as an encore, made one of the great hits of the evening. Miss Lucy Wheeler's pretty dancing was a new feature in our Ward concerts, and, although performed perhaps under somewhat trying circumstances, was a performance which was much enjoyed. Miss Kindon sang "An Old Garden" and "Bid Me Good-bye" very prettily; and Miss Burge gave us "Sunshine Above," followed by an encore. Mr. G. C. L. Fry sang "Father O'Flynn" in stirring style; his encore "Shillin'-a-day," was also re-demanded. Mr. Aspinall, in spite of a cold, sang two beautiful tenor songs to good effect, and his amusing story about the "Wry-mouthed Family" simply put everybody in fits of laughter. Another feature was the sketch, entitled "A Pair of Lunatics," which was ably acted by Mr. and Miss Spon, and much appreciated by everyone. Besides the above, whom we have to thank so much for their kindness in helping to entertain our patients, the following materially contributed towards the success of the evening—Messrs. Coulson, Hicks, Thomas and Michael. The arduous duties of accompanying were ably performed by Miss Spon and Mr. Hardenberg. "Auld Lang Syne" made an appropriate finale to a very enjoyable and convivial evening.

New Year's Day afforded another pleasurable occasion for the younger patients in the wards of the hospital, when an excellent Magic Lantern Show, provided, we understand, through the kindness of Sister Luke was given before a large assembly in LUKE ward. Views of some of the beautiful spots to be met with along the course of the Thames were presented, followed by scenes descriptive of a story, as usual, "Struwel Peter," in character, the entertainment concluding with a number of representations of the comic order, which hugely delighted the more juvenile members of the audience.

Later in the evening LAZARUS was the scene of yet another concert, in which the Hospital songsters again came to the fore, their voices, however, betraying signs of the hard work to which they had willingly been put during the previous week. Though the affair was an impromptu one—many of the performers, amongst whom were several ladies, giving their services at the last moment—it was none the less enjoyed by the large number of patients present. In addition to those we have before mentioned, the following were also instrumental in the success of the evening:—Messrs. T. L. Jackson, V. Pendred, Ham and Hora ("I Fear no Foe in Shining Armour"), and some ladies kindly introduced by "the Colonel."

On Thursday of last week, the long series of concerts and entertainments given in such profusion in the Wards this Christmas was brought to a termination in a most enjoyable manner. An entertainment—the like of which, we are sure, has seldom been held in Guy's before—was given before the "Bright" patients and their friends, and many other invited guests, who numbered quite 300. Addison ward, when we entered it, had been transformed by Messrs. Whiteley. The left hand side was converted into a miniature theatre, the stage being at the north end; the walls were very prettily draped in soft, coloured material and wreathed. The eastern block was converted into a most luxurious tea lounge, and must have occasioned the workmen no inconsiderable amount of hard work and ingenuity. A handsome chandelier hung from the centre of the ward, which was curtained all round with light drapery. Candelabra were displayed on small and large tables, which were most artistically arranged for tea and light refreshment: while the floor was covered with soft Indian and Kurd rugs, and numbers of comfortable chairs and lounges were disposed here and there, seeming to invite the company to pleasant social conversation and chit-chat. Amongst those present were the Treasurer, many of the Members of the Staff, the Sisters, the Residents, and Clinicals.

At the entertainment, which was very excellent throughout, several of the leading London artistes kindly gave their services, and it is to Miss Sylvia Grey and Mr. A. K. Ellworthy that we are chiefly indebted for their presence on the occasion. Proceedings began with an overture by the first-rate orchestra under the able direction of Mr. Ellworthy, after which "A Happy Pair" was well presented by Mr. Edward and Miss Blanche Beecher. Miss Sylvia Grey recited "Her Letter," by Bret Harte, in a taking manner; and Miss Rosina Brandram, who was in splendid voice, sang "London Bridge" in a most impressive style. The now famous Japanese song and dance from "The Shop Girl" was performed with great spirit by Miss Katie Seymour and Mr. Frank Wheeler, who kindly acceded to the vociferous call for encore. Mr. Eric Lewis gave an amusing musical sketch of his Scotch experiences, which was much appreciated; and Mr. Courtice Pounds was heard to advantage in "Come into the Garden, Maud." Miss Carrie Samuel was responsible for a finely executed violin solo; and the Misses Kate Cutler and Maria Davis gave the "Dear Mamma" duet from "In Town" with such vigour as to cause it to be undeniably encored. A second overture from the orchestra, and the curtain was rung up for "Outwitted," a musical farce by Miss Isabel Grey. The rôles were performed by Messrs. Austin Leigh, Edward Beecher, Henry Beaufort, Miss M. Blandford and the Authoress, and the farce went merrily from start to finish. During

the afternoon the Treasurer graciously presented the lady artistes with handsome bouquets, thanking each of them for her kindness in giving her services. At the conclusion of the entertainment the company adjourned to light refreshment, and shortly afterwards departed, having thoroughly enjoyed themselves.

To Sister Bright, the patients and other visitors are greatly indebted for the charming afternoon, and we can assure Miss Ellworthy that her kindness was much appreciated.

A Physiological Discovery (?).

MR. F. D. FISHER, J.P., of Grantham, claims to have made an important physiological discovery, the result of which is embodied in pamphlet form. The substance of this discovery is that the bowels form part of the circulatory system, and are in direct communication with the venous system, the true function of the lymphatics being to supply nutriment to the body. The writer bases his claims upon personal experience. Various symptoms of ailments with which he was afflicted, and their treatment, which led to the discovery, are detailed. The treatment referred to consisted in rubbing and massage of the abdomen. It was invariably successful in giving relief from pain. Not a medical man himself, the writer is not tied down to accepted theory. He does not share the general belief that the blood of the portal vein passes through the liver by the hepatic veins, but is inclined to the opinion that its normal flow is in the direction of the bowels, the liver acting in cases of obstruction as a safety valve, and the heart as a force pump, pumping blood from the venous to the arterial system. He proceeds to illustrate this by the function of digestion. In suggesting that constipation is the source of all human maladies, the writer brings his pamphlet to a close.—*Grantham Journal.*

The British Medical Temperance Association.

THE Council of the British Medical Temperance Association offers three prizes of £5, £3 and £2 for the best Essays on the Arguments derivable from Physiology for Total Abstinence from Alcoholic Liquors. Conditions:—(1) Competitors must be Medical Students now in their Third Winter Session. (2) Essays must be written on one side of the paper only, and must not exceed 6,000 words; they should be type-written or in clear handwriting. (3) Essays should be marked with a number of four figures and be accompanied by an envelope similarly marked, containing name, address, Hospital School, and certificate of being in Third Winter Session. (4) Essays must be sent to Dr. Ridge, Enfield, by March 30th, 1895.

Pass List.

University of London, December, 1894.

B.S. EXAMINATION.

EXAMINATION FOR HONOURS.

Davies, Hugh, obtained the Gold Medal.

B.Sc. EXAMINATION.

FIRST DIVISION.

CHEMISTRY, ZOOLOGY AND ANIMAL PHYSIOLOGY.

Turner, P., obtained Honours in Zoology.

SECOND DIVISION.

CHEMISTRY, ZOOLOGY AND ANIMAL PHYSIOLOGY.

Richmond, G. E.

University of Cambridge, December, 1894.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.

Clarke, A. V. — Henderson, E. E.
Cooper, C. E. — Peters, E. A.

PART II.

Bond, C. S. — Henderson, E. E.
Clarke, A. V. — Key, B. W. M. A.
Field, G. H. — King, T. P.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.

PHARMACEUTICAL CHEMISTRY.

Lindsay, W. J. — Thomas, F. G.

Guy's Hospital Dental Department.

PRACTICE DURING DECEMBER, 1894.

Gold Fillings		163
Amalgam ,,		420
Osteo ,,		
Perm.G.P.,,		
Regulations		3
Artificial Crowns		41
Dentures		12
Dead Teeth		91
Scalings		23
Dressings		
Attendance for Extraction under Anæsthetics		649
,, ,, without ,,		490
Advice		
Total		1892

Passim.

THE Index to the volume of the GAZETTE for 1894 is now ready. Copies may be obtained on application to the Librarian. Subscribers who may wish to have the volume bound in blue cloth, with the arms of the Hospital in gold, should leave their copies with the Librarian. The charge for binding is One Shilling and Sixpence.

WE are pleased to hear the satisfaction pretty generally expressed at the framing of our Christmas Presentation Plate, which we have undertaken to have executed at the small outlay of Three Shillings. Orders for extra copies of the plate should be delayed as little as possible, as there are but few remaining. The issue of the GAZETTE itself for the 29th ult. is already exhausted.

THE entertainments and concerts which have been held during Christmas-week have never been so numerous nor yet so elaborate, and we all owe a debt of gratitude to the artistes, who, no doubt, with a good deal of personal inconvenience, have so freely given their services on these several occasions.

THE following has found its way into the Editor's Box from the Nurses:—"It is the earnest wish of the Nurses to show their gratitude and warm appreciation of the efforts made for their amusement this Christmas by the Residents of Guy's Hospital. Both first and second audiences enjoyed the Concert immensely, and, knowing no better way than through the medium of the GAZETTE, they gladly take advantage of its pages to heartily thank all those to whom they are indebted for their Christmas entertainment. They feel keenly the thorough good nature, which spared no trouble in order to add to their enjoyment; and if by any they were thought cold and unappreciative, it should be remembered that "still waters run deep," and 'tis un-English to be demonstrative."

WE have to chronicle an appointment of more than passing interest. Mr. Wordsworth Poole, M.B., B.C. Cantab., who has just completed his term of office as House-Surgeon at this Hospital, has been appointed by the Foreign Office, Medical Officer to the British Central African Administration at Zomba, in the Shire Highlands, south of Lake Nyassa. The protectorate has been three years under British government, and has made great strides in prosperity. We congratulate the Foreign Office on their choice, and to Mr. Poole we tender our sincere wishes for his welfare.

HEARTY congratulations also to Hugh Davies on his success in the B.S. Honours Examination. To have gained the second place, with the additional distinction of obtaining the Gold Medal, is an achievement of which he may well be proud. The Gold Medal has not come to a Guy's man since 1889, when C. McG. Kitching was successful.

MANY of our readers will be interested to hear that that distinguished Guy's man, Dr. D. W. Samways, has, for personal health considerations, settled down to practise in Monte Carlo.

THE Hospital is soon to lose a familiar and respected figure. It was with genuine regret that we heard the announcement that, in consequence of failing health, Parsons had sent in his resignation of the post of Porter at the Top Lodge. We feel sure that he will not be allowed to depart without receiving suitable acknowledgment of the general esteem in which he is held. For ourselves we hope to preserve his memory by publishing some fuller particulars of his career.

WHATEVER feelings our "mistaken cynicism" may have aroused with regard to the Postman's Christmas-box, it has certainly had one excellent effect, and it is extremely gratifying to learn that, thanks to the efforts of the Librarian and College Porters, a very handsome sum has been collected for so good a cause this year.

THE new Students' Calendar is now ready, and may be had on application at the Library, or at the Medical School Office. Particular attention is directed to the information to be found on the back. The Dental Students' Calendar —another useful document—is also ready.

WE have been asked to announce that the Syllabus for the Entrance Scholarship Examinations, to be held in September next, are now published, together with the Examination Papers set in these and in the other School Examinations during the past year. Any, or all, of these pamphlets may be readily obtained from the Medical School Office.

Case of Fracture of Skull.

COMPOUND, COMMINUTED AND DEPRESSED FRACTURE OF THE SKULL; OPERATION; RECOVERY.

I have written out my notes of this case, in the hope that they may be of interest to the readers of the GAZETTE, and as illustrating some of the difficulties met with in surgery in country practice.

On April 5th, 1888, at 4 p.m., I was asked to see J. B., aged 57, at his cottage. I found him sitting in a chair, leaning forward, with his head on his hands. Said he felt "a bit stupid," but in no pain. He told me that at eight o'clock in the same morning he was engaged as a bricklayer's labourer in cleaning bricks at the ruins of a house which had lately been destroyed by fire, when a loose brick fell from the top of a high wall and struck him on the back of his head as he was in the act of stooping down. He was wearing a thick fur cap at the time, and when struck, he fell forwards on to his hands and knees. He did not lose consciousness, but was at once picked up by his mates, and, with their assistance, walked to a shed about two hundred yards away, where he sat down and had the wound washed. He then waited for half-an-hour, and finally drove in an open cart to his home at Emsworth, a distance of sixteen miles.

Beyond being somewhat tired from the long drive, he was apparently all right. On removing the handkerchief which was tied round his head, I saw a deep wound, irregularly circular, with torn ragged edges gaping half-an-inch, about three-quarters of an inch in depth, and two and a half inches in length. Two fingers might easily have been inserted in the wound. I could see the skull was fractured and depressed. A probe passed three-quarters of an inch to innermost edge of the depressed fragment. After this temporary examination he felt giddy and sick, but did not fall nor vomit. The man was in a filthy state; head simply alive with vermin; scalp and body generally begrimed with the dirt of months; bedroom and surroundings were in an equally dirty condition. As the depressed bone was causing no symptoms of compression of the brain, I determined to get his surroundings as aseptic as possible before operating, so simply irrigated wound with 1 in 40 carbolic lotion, packed with iodoform and gauze; prescribed calomel, gr.v. and ordered half-a-pint of milk during night; to be kept absolutely quiet, with ice-bag to head.

Early on the next morning I had the room scrubbed with strong carbolic soap and lotion (1 in 30); the bedstead and bedding removed entirely and replaced by new and clean; the walls and ceiling limewashed; the man himself scrubbed from head to foot, and clean clothes put on.

April 6th, 12 a.m. Says he is very comfortable and feels quite well; refuses to go to hospital. I decided to operate at once. 4 p.m., anæsthetic administered by Mr. Palmer Stephens, also an old Guy's man, and assisted by my sister, who acted as dresser *pro tem.*; head shaved, whole of scalp well washed with soap and water, followed by carbolic lotion (1 in 40). I found that just to the right of the median line and at the apex of the Lambdoidal suture was the scar of an old crucial incision as for trephining depressed at the point of meeting of the scar-lines. The wound began at the end of the right horizontal scar. A longitudinal incision was made through the whole thickness of the scalp down to the bone for three and a half inches above and two inches below the centre of the wound. On dissecting back the scalp, an old trephine hole was seen with smooth bevelled edges, across which dura mater was seen to be thick, strong, pulsating firmly and regularly at seventy per minute. Along the posterior segment of the trephine hole were two small loose fragments of bone; more to the right of this was a large piece the size and shape of a shilling, depressed at its posterior edge to three-quarters of an inch, and causing firm pressure upon the dura mater. This fragment was elevated, and being quite loose, was removed. The edges of bone were carefully examined for sharp points or loose fragments, but none were found. So far as could be seen, the dura mater was not punctured. All bleeding points were secured. The wound was irrigated with carbolic lotion (1 in 60); iodoform was dusted in; drainage tube inserted; edges of scalp wound brought together with five silk sutures, and gauze dressings applied. Spray used throughout operation.

7th. Temperature, 99·4; pulse, 72; respiration, 17. In no pain; slept well; feels all right; inner dressing sutured with thin, blood-stained serum; wound quite sweet; removed and shortened the tube, syringed out wound and replaced tube. Edges of wound uniting, and in good apposition. Tongue clean, but breath tainted.

8th. Temperature, 98·2; pulse, 76; respiration, 17. Feels well; no pain in wound; no headache; very hungry; wound dressed; removed tube entirely.

9th. Temperature, 98; pulse, 64; respiration, 16. Wants to get up. To have tea and toast, bread and milk, broth.

10th. Temperature, 98; pulse, 72; respiration, 17. Sutures removed; wound quite healed, except where tube was inserted. Fish and vegetables for dinner.

12th. Walked downstairs, and sat out in garden. Went to work on April 22. Is quite well at present time.

Previous History.—I elicited the following history, during his convalescence, as to the old trephine note found at the time of operation.

When nine years old, he fell from a horse, was able to pick himself up, and walked about a quarter of a mile. Remembers being told that the doctor had to take out a piece of bone.

When eighteen years old, was buried in a gravel pit, under a fall of earth, to such an extent, that five men took two hours to dig him out. Apparently, he sustained some injury to his pelvis, as he had to have a catheter passed night and morning for three months after. Has

never been free from a certain amount of difficulty in micturition since that time.

When twenty-five years old was struck on the head by a large piece of timber; was insensible for nine days, and unable to work for nine months. Has had well-marked right internal squint, and has been deaf on the right side ever since this accident. For at least twelve months afterwards, he always walked towards the left side. Has no other accident of interest until the present occasion.

Several interesting points may be noted in this patient's history:—

(i.) From the nature of the accident, the walk and the long drive after receiving such a blow, one would have expected more marked symptoms of head-injury than were found.

(ii.) The old trephined hole was a source of relief to the extra pressure thrown upon the brain by the depressed bone.

(iii.) The value of careful and minute antiseptic precautions, not only in the wound itself, but also in the surroundings of the patient.

(iv.) The value of a free longitudinal incision through the scalp in exposing a fracture of the skull, as compared with the usual crucial incision, especially where there is a lack of skilled assistance.

(v.) The presence of symptoms due to old standing causes, such as the squint and the deafness.

Emsworth. LOCKHART STEPHENS.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Specialism in Medicine.

Sir,—The eminently interesting article of Mr. Mac Ilwaine, published in the GAZETTE dated December 29th, touches a subject that most general practitioners feel rather strongly upon, I believe—I think I quite see at least one of his points: that a man should not be utterly regardless of other parts of the body in his diagnosis, even if he is a specialist, and I do not believe he is often. Obviously, if a patient comes to you with a throat which may be cancerous or syphilitic, if you are a specialist, you will hunt round in the usual way for evidence of the latter, and make enquiries as to the former; but believe there is a need for specialism, and for a man who works not too narrowly, which is quite possible, his wider experience must necessarily be of more value than that of a man who has for any reason less chance of seeing a number of cases of a similar type. It is reported, I do not know in the least how truly, that a very distinguished physician, confining his practice entirely to the upper air passages, said: "Take this person away and treat her, I never want to see another case of tonsillitis as long as I live." This was an out-patient. Well, Sir, this gentleman might have been tired, or ill, or worried, or lazy, but he must surely miss some cases of purely "medical" origin, unless his diagnosis is so quick and accurate as to constitute a miracle or an impossibility, which you please. Why should not a man be a specialist, if he has the wits, and the money, and the time and the influence, perhaps? But if it is merely a matter of students, I mean hospital students, acquiring perfect knowledge, I should like to ask, even if they have time and money and so forth, and ability and power to consecrate their time to attempting to learn all things relating to disease, at what time of life are they likely to be able to use their wings and leave the Alma Mater—for one cannot hold them all for ever. It is impossible—I think a little knowledge, in spite of the adage, is distinctly better than none at all! How, in the name of common sense or anything else you like, can any out-patient physician or surgeon demonstrate to a crowd of students every part of the human frame, in every case, with the waiting-room full to overflowing? There was an imperative call for a division of labour, and of course it has its faults like other things, but it is the best working idea at present.

It may be a man's misfortune or his fault that he leaves his hospital too soon, and the longer he remains at work the better; but it is not possible for every man, and so he must lay what foundation he can in the time that is possible to him. That days of deep regret will come later is almost certain; but if he must work on his own account early, he need not give up all chance of acquiring a certain amount of special knowledge later on. I once asked one of the most distinguished anatomists living, why I should be required to know the exact position of Bochdalek's ganglion, adding that I did not see it was of any particular use to me! He replied, "From the pleasure it should give you to know everything about everything." On my suggesting that my intellect was not big enough for that, nor my life likely to last five or six hundred years, he told me—"You must try!" And I believe that is really all you can do. I would much prefer to do one thing well, than any number of things fairly only, like countless other men; but I do not believe people do things really well except after an enormous amount of experience.

In conclusion, the notion seems desirable (as the millenium, I believe, is considered to be) but perhaps somewhat idealistic, and at any rate cannot be accomplished our time any more than the Matterhorn will be rubbed down by next year.—I am, yours faithfully,

Jan. 1, 1895. ARTHUR WILLIAMS.

SIR,—There appeared recently in the GUY'S HOSPITAL GAZETTE a lengthy article under the heading "Specialism in Medicine," in which the writer in a few lines sums up the claims of Dentistry to be regarded under the title of his essay.

The plea of your contributor was one for a broader compulsory curriculum, the urgency of which has apparently been brought home to him with his experience of practice. That he himself has suffered from the lack of it is evident from the casual manner in which he relegates dentistry to a place outside medicine. If by medicine is meant "the art of preventing, curing or alleviating disease," and specialism means a special department of this art, then dentistry is a specialism of medicine. That dentistry is obviously dependent on all the other branches of the healing art is evident by the extent of its educational requirements, as the following contrasted tables show:—

REQUIREMENTS FOR L.D.S. ENG. NEW REGULATIONS.	REQUIREMENTS FOR L.R.C.P., M.R.C.S., ENG.
Chemistry and Chemical Physics.	The same.
Practical Chemistry.	,,
Materia Medica.	Pharmacy—"Instruction." Biology.
Anatomy—One course.	The same.
Dissections—Twelve months.	,,
Physiology—One course of lectures.	,,
Practical Physiology—Three months.	Six months.
Medicine—One course of lectures.	The same.
Surgery—One course of lectures.	,,
Surgical Practice—Two winter Sessions.	Surgical Practice—Two winter and two summer sessions.
Clinical Lectures on Surgery—Two winter Sessions.	Clinical Lecture on Surgery—Nine months.
Dental Anatomy and Physiology. Two courses of lectures.	Systematic Practical Instruction in Medicine, Surgery, and Midwifery.
Dental Surgery—Two courses.	Clinical Lectures on Medicine—Nine months.
Dental Mechanics — Two courses.	Pathology—One course of lectures, and morbid histology.
Metallurgy—One course.	Forensic Medicine, Public Health, Pharmacology — One course of lectures.
Dental Practice—Two years.	Midwifery, &c.—One course of lectures, and twenty cases.
	Instruction in Vaccination.
	Medical Clinical Clerk, Surgical Dresser—Six months for each appointment.
	Medical practice—Two winter and two summer sessions.
	Medical and Surgical Practice—One year from Third Examinations.
	Instruction in Fevers, Lunacy, and Ophthalmic Surgery.

Dental practitioners are amenable to the General Medical Council, established under the Medical Act of 1858, and a person cannot now practise dentistry unless his name be upon the Register, which necessitates his being a licentiate of the College of Surgeons.

Mr. MacIlwaine asserts that "if a man calls himself a dentist he ought clearly to resign the title of surgeon." In my experience, he usually does so, for he either styles himself "dentist" or "dental surgeon." I take it, although he does not so state it, that he objects to the assumption of this latter title, and yet by his Diploma a dentist is licensed to practise dental surgery, and by the Dentists' Act of 1878 any person other than one registered under the Act who assumes this description is liable to a penalty of £20. Personally I am content with the term dentist, but, on the other hand, I am clearly entitled to call myself surgeon, if I choose.

Again, it may be that Mr. MacIlwaine regards dentistry as a purely mechanical art rather than a scientific calling. It cannot be other than a combination of both—the art is the practical expression of the science. Unless an operator has knowledge of the relations of the organ he is dealing with to the phenomena exhibited in the contiguous tissues of the oral cavity, and reflexly, or otherwise, in other situations, his proceeding is purely empirical. There is a territory between general and dental surgery, as there must be between any specialism and general medicine, where the surgeon and dentist meet, and I assume that it is Mr. MacIlwaine's estimate of the extent of the province of the dentist into this "terra incognita" that enabled him to pass sentence upon dentistry.

The thin web which he sees connecting dentistry with medicine I break, willingly resigning the administration of anæsthetics to my confrères in specialism, the anæsthetists.

Hampstead, N.W. MONTAGU F. HOPSON.

Pupils' Physical Society.

AT the Clinical Evening of this Society, held on Saturday last, in the Library, the following cases of interest were shown:—

1. Double Genu Valgum. By Mr. Vellacott.
2. Tumour of Breast, with a very long history, thought to be Scirrhus; and
3. Symmetrical Ulceration of Legs. By Mr. V. Pendred.
4. Pulpy Knee, palliative Treatment. By Mr. R. F. Clark.
5. Aphasia; and
6. Exophthalmic Goître. By Mr. Steinhauser.
7. Cerebral Tumour. By Mr. Kay.
8. Exophthalmic Goître; and
9. Double Facial and Auditory Paralysis, specific. By Mr. Duffett.
10. Congenital Heart Disease. By Mr. W. J. Rowland.
11. Friedreich's Disease. By Mr. Spicer.
12. Locomotor Ataxy in a Woman. By Mr. Plummer.

Reviews.

Artificial Feeding and Food Disorders of Infants. By W. B. Cheadle, M.A., M.D. Cantab., F.R.C.P. (Smith, Elder & Co., London). Price 5s.

The third edition of Dr. Cheadle's book does not call for much comment. The subject is one which, in most books, is dismissed with a few vague remarks, altogether disproportionate to its great practical importance. Dr. Cheadle's book, therefore, supplies a definite need, and can be warmly recommended to all who are likely to be called upon to treat young children. Not the least valuable pages in the book are those devoted to the mode of preparation of artificial foods, such as treated milk, beef tea, raw meat juice, etc. The second part of the book deals with the diseases induced by faulty diet. In this portion, we think that the author might with advantage have discussed the gastro-intestinal disease of infants at somewhat greater length, but since these conditions are treated very fully by Goodhart, Donkin, Smith and others, the omission is not of much importance.

Handbook of Public Health and Demography. By E. F. Willoughby, M.D. Lond. (Macmillan & Co.). Price 4s. 6d.

Although the author of this little volume is dogmatic, and, at times, not very considerate towards the various authorities with whom he disagrees, yet he treats the subject from a more scientific standpoint than is usual with books upon public health. Several sections of the subject, which in many larger treatises are either ignored or described very briefly, are here dealt with at considerable length. The author's division of the subject is quaint, but rather forcible; he classifies it under four heads: "Health of the man," "Health of the house," "Health of the city," and "Health of the people." The last of these includes a valuable section devoted to school hygiene, and this may well be recommended to the notice of those who are responsible for the erection of the numerous unhygienic Board schools. The section dealing with Demography is somewhat condensed, and, in consequence, rather dry. However, it contains numerous valuable tables.

Manual of Disease and Deformities of the Spine. By R. L. Swan. (Fannin & Co., Dublin). Price 7s. 6d.

It is a little difficult to see why this book should have been written. Apparently it does not contain anything very new or original, nor, indeed, can it be said to have summarised our present knowledge of the subject, for although the author has consulted many authorities, yet his list of references is by no means a complete one. The illustrations form the most striking feature of the volume; these, in some cases, are realistic in the extreme. Perhaps, also, it would have been better occasionally had there been more of the patient and less of the nurse. However, from one point of view, the book is of importance, in that the author is a surgeon of wide experience, whose opinions, of necessity, have a certain value.

Manual of Practical Morbid Anatomy. By H. D. Rolleston, M.A., M.D., F.R.C.P., and A. A. Kanthack, M.D., M.R.C.P. (The University Press, Cambridge). Price 6s.

This volume may be described as a handbook for the dissection, rather than for the simple examination of the body, after death. No doubt it would be very advantageous if the instructions of the authors could be carried out in every detail; but where several post-mortems have to be done in a single afternoon, it is simply out of the question to spend as long over each as would be necessary under these conditions. It is very evident that the authors have been considerably influenced, in the directions which they have sometimes given, by the pathologist's fear, lest the somewhat rough treatment so frequently bestowed upon organs in the post-mortem room should render them useless for further examination and preservation. The various pathological conditions are dealt with somewhat unequally, some being described at considerable length, whilst others are dismissed with a few lines; moreover, it is to be regretted that the authors have not more frequently adopted a tabular system of description, which would have added both to the clearness and conciseness of the directions. The book, however, contains many most valuable hints, and will undoubtedly be very useful to those who have themselves not had a very wide experience in the art of making post-mortem examinations.

Illustrated Catalogue of Chemical Apparatus. By John Griffin & Sons, London.

We have received a very comprehensive catalogue of the various kinds of chemical apparatus, as sold by Messrs. Griffin. It is printed on good paper, and the illustrations have been carefully selected, and well executed, whilst the prices compare favourably with those of many other manufacturers of chemical apparatus. Special attention may be drawn to the lists of apparatus necessary for the examination of urine, and to the appliances used in bacteriological research; the latter includes a selection of staining re-agents, and of culture media.

Inorganic Chemistry for Beginners. By Sir Henry Roscoe, F.R.C.S., D.C.L., LL.D., M.P., assisted by Joseph Lunt, B.Sc. (Vict.), F.C.S. (Macmillan & Co.). Price 2s. 6d.

This little book may be described as the A B C of Chemistry, or as an introduction to Sir Henry Roscoe's Elementary Lessons in Chemistry. From the publisher's point of view, it is evidently produced for the benefit of students of science, who wish to restrict themselves to the requirements of the examining board of the Department of Science and Art; further, it is, no doubt, very suitable for use in schools. So far as it goes, it is a very good book.

Appointments.

SINCE our last issue the following vacancies have been filled up:—

Aural Surgeon's Dressers.—Messrs. H. J. Spon (January); J. J. E. Biggs, B. W. M. A. Key (March).

Dental Surgeons' Dresser.—Mr. J. H. Horton (March).

Post-mortem Clerk.—Mr. R. H. Ashwin (March).

Obstetric Ward Clerk.—Mr. P. C. Higgins.

Obstetric Out-Patient Clerks.—Messrs. C. H. Bryant (first half); A. P. Beddard (second half).

Surgical Ward Clerks.—Messrs. C. C. Poole, W. J. Lindsay.

Assistant Surgeons' Clerks.—Messrs. B. A. Richmond (Mr. Jacobson); F. W. Lee (Mr. Symonds); C. Jephcott (Mr. Lane); F. H. Hardy (Mr. Dunn).

Clerks in the Electrical Department.—Messrs. R. H. Hayes (January); J. H. Horton (February), H. Alexander (March).

Clerks in the Skin Department.—Messrs. W. J. Rowland, O. Beven, G. Gocher.

Dental Appointments.

JANUARY, 1895.

Dressers in the Gas Room.—Messrs. E. C. Dimock, F. E. Händel, B. Edgar James, A. Read.

Dressers in the Ordinary Extraction Room.—Messrs. E. D. Bascombe, L. Bidlake, J. M. C. Jacobs, G. Naish, N. Snell, L. Ta'Bois.

Notes from Country Practice.

A VILLAGE IDYLL.

IT is a winter's day, with drizzling rain falling. The doctor and a shivering tramp are standing at a stable door. On the rising ground to the left stands a fine red-brick rectory. To the doctor's knock the door opens. The doctor enters, while the tramp slinks away.

The stable is a well-built two-stalled one. In one corner is a group of village women, in a state of great merriment, surrounding a centre of attraction—a new-born boy, lobster-like, and crying after being washed. The mystery of swaddling is being conducted by a burly, handsome midwife, whilst the others assist by toasting the new arrival in gin, taken neat from a soda-water bottle. Lying on the unclean covering of the stable floor, is a young, soft-featured woman, dressed in clothes once black, but now green with wear. She leans on her left side, resting her head on her hand, and looks through the large gap between the door and the ground—through which a keen blast of wind blows straight upon her—with the dreamy look of a woman who has accomplished her task, and is too weak to grapple with past regrets or future fears. Her teeth are chattering, for her soaking clothes have not been removed.

The husband, wife and two children were on their way to the infirmary, but, owing to the urgency of the case, the rector's wife had kindly allowed the confinement to take place in the stable.

The doctor walked up the drive to the rectory, and was ushered into the drawing-room. The walls were covered with bad water-colours and glaring texts; whilst on the tables were scattered about missionary books, "The Gospel in all Tongues," and other similar productions. The rector's wife, a harsh-voiced woman, was good enough to send down the servant with some rugs for the woman, with the injunction that they were not to be made dirty.

The village women gave the husband and children dinner, and added baby linen, a warm petticoat, a knitted jacket, some blankets—and coarse, gin-begotten jests. Towards evening a covered van took the mother and child to the infirmary.

Next day the relieving officer and doctor met. They both smiled cynically. "When I went into the stable," said the officer, "she was feeding the woman with some gruel, stretching out her arm as though she was another kind of animal altogether. She said she hoped the horses wouldn't catch cold from being turned out into the rain." Born in a manger, and was there no room in the rectory? thought the doctor.

W. P.

Medical Education in Japan.

THE calendar of the Imperial University of Japan is very interesting to read, and recent events in the far East will have prepared the Conjoint Board to find that they may learn something from a perusal of the regulations of the College of Medicine at Tokyo, which form part of the calendar.

While commending the book to Mr. Hallett's earnest consideration, we would draw attention to one or two points that struck us on a cursory examination:—"A candidate who has failed thrice in the examinations is thereby debarred from presenting himself at any future examination." Tremble, oh, chronics, for when this salutary rule is introduced here you won't be able to evade it by not going up, for it will be accompanied by the following: "If any student fails more than twice to undergo the examinations in the proper terms, he may be dismissed." But, joking apart, wouldn't this be a good rule? For, if it is slackness which causes the failure, no man who cares for his profession will fail three times; and, if it is density, he has clearly mistaken his vocation.

"In the clinical examinations, candidates are required to treat one or two patients during a period of one week." This sounds a little hard on the patient, unless the prescription is overhauled to see that it does not contain a poisonous dose, and rather hard on the candidate if success in degree-getting is dependent on success in treatment.

A very salutary regulation appears to be that during the week of examination the candidate "goes round every day with the examiner," which seems more satisfactory than a twenty minutes' viva.

The written examination is conducted in a curious manner, which is too briefly described to be quite intelligible:—"Each candidate is required to answer the questions which have fallen to him by lot. The examiners select twenty-five to thirty questions on the subject, at the beginning of the terms in each year." The value of this arrangement depends on whether the candidates are made aware of the examiners' selection at the beginning of the term. Perhaps it is only devised to prevent favouritism by examiners who are also teachers.

Altogether, the methods of education and examination seem, on paper, to be very complete and advanced at Tokyo, but perhaps some of your readers who have the advantage of practical acquaintance with the ways of their University could give further information in your columns; the Admiralty do not seem to be above taking wrinkles from Japanese naval tactics.

Malaria.

A Paper read before the Physical Society on December 8th, 1894, by Mr. W. S. HANDLEY.

MR. PRESIDENT AND GENTLEMEN,—The subject I am allowed the privilege of speaking about this evening, unlike, for instance, that of diphtheria, on which a paper was read a short time ago, is not one of great practical interest, but it has, I think, very great scientific interest, because the discovery that malarial fevers are due to protozoa opens up an entirely new field of pathology, and one of unknown extent.

The poison which causes marsh fevers, for that is what I mean by "malaria," is known to exist, (*a*) in the external world; (*b*) within the body.

Certain facts as to malaria outside the body, such as the conditions of soil, climate, etc., which favour its development have long been known, and a repetition of them would be wearisome. It is chiefly about the malarial poison within the body that I propose to speak.

In 1880, while the *bacillus malariæ* of Klebs and Tommasi-Crudeli was at the height of its vogue, Laveran, a French military surgeon in Algiers, noticed in fresh specimens of blood from malarial patients certain rounded or crescentic hyaline bodies differing from leucocytes in not possessing a visible nucleus. On November 6th, 1880, he saw attached to one of these round bodies flagella in rapid motion, lashing the red corpuscles hither and thither like whips, and even indenting the corpuscles. He jumped to the conclusion that he had discovered the parasite of paludism, and time has proved him to be right. His observations were neglected for some years, but have now been confirmed even by those who at first scoffed at them.

Laveran gave to the organism the name *hæmatozoon malariæ*, and described it under four forms:—

1. Rounded amœboid bodies, the commonest form.
2. Flagella, only occasionally seen.
3. Crescentic bodies.
4. Segmented or spore-forming bodies.

The amœboid bodies vary in size from one to ten μ, and are composed of a hyaline substance having a very delicate contour. They are usually attached to, or more probably enclosed within, a red blood-corpuscle, but the larger ones are sometimes free in the plasma. The smallest are seen as minute transparent dots, like vacuoles, on the surface of the red corpuscle; those a little larger contain a granule or two of black or reddish-brown pigment, while the still larger form contain many pigment granules, which are often in rapid motion, resembling Brownian movement, but not so regular or continuous. In examining the blood, these pigment granules seen in the red corpuscles direct the eye to the delicate outline of the hæmatozoon, whose shape can be seen to alter from minute to minute. The parasite possesses a nucleus, but this is invisible in fresh specimens. As the hæmatozoon grows and accumulates pigment, the blood corpuscle becomes pale and increases in size as if it were dropsical; finally, only its outline can be seen surrounding the parasite, like the skin of an orange which has been sucked dry. Mannaberg has seen a mature hæmatozoon escaping from the shell of the blood-corpuscle it had developed in.

The larger amœboid bodies sometimes possess one to four flagella, three or four times the diameter of a blood corpuscle in length, and so transparent that it is difficult to see them when at rest, but when in motion their lashings and twistings among the corpuscles are described as one of the most wonderful sights it is possible to witness under the microscope. Laveran occasionally saw a flagellum become detached and swim off rapidly among the corpuscles on its own account, and he believes that these free flagella have an independent existence, and are perhaps the developed form of the hæmatozoon, but since their structure is homogeneous without nucleus or nucleolus, it seems more reasonable to suppose, as do most writers on the subject, that they are simply organs of locomotion, which may accidentally become detached.

The crescentic forms are transparent cylindrical bodies eight to ten μ long, curved in the form of a crescent, with tapering ends. Massed at their centre, or more or less scattered, there are invariably granules of pigment; and occasionally, on the concave side of the crescent, can be seen a faint curved line joining the two horns, and representing all that is left of the parasite's unfortunate host, the red corpuscle.

Laveran believes that this is the encysted form of the hæmatozoon, because it is immobile and sometimes has a double contour. This is borne out by the fact that it lingers in the blood of malarial cachectics and of patients dosed with quinine after other forms of the parasite have disappeared. Mannaberg believes that the crescentic form results from the conjugation of two amœboid bodies. The ultimate fate of these crescent bodies is quite unknown; probably they break up into spores, but this is mere conjecture. The segmented bodies are rounded, motionless, pigmented in the centre,

and divided into segments by radiating lines. They are, in fact, the amœboid bodies in process of spore-formation.

Golgi first fully observed this process in the blood of patients suffering from typical quartan ague. The first change is that, in a mature amœboid body occupying the whole of a corpuscle, delicate radiating streaks appear, while at the same time the pigment granules become massed together at the centre. The streaks become more obvious, and soon the parasite is divided by them into about six to twelve oval masses arranged round the central mass of pigment like the petals of a daisy round its corolla. Finally, the hæmatozoon breaks up into from six to twelve small oval spores, and a débris of pigment and residual protoplasm is left to be cleared away by the leucocytes.

But the most important facts that Golgi noticed were that in cases of typical quartan fever the parasites were all at about the same stage of development, and that the breaking up of the generation of mature parasites into spores coincided with or just preceded the onset of the paroxysm of fever.

During the paroxysm no segmented bodies were visible, but the corpuscles were infested by very small unpigmented and actively amœboid parasites evidently derived from the recently liberated spores.

During the two days of apyrexia, these small unpigmented parasites increased in size, and acquired pigment continuously until six to ten hours before the next paroxysm was due, when they began to show signs of commencing spore formation.

Golgi also laid down the important general rule that the severity of the attack is proportionate to the number of parasites found, and this has been confirmed by Mannaberg and others. It is, however, not invariably true, for a severe attack may occur with but few parasites. It is probable, in these cases, that the parasites would be found in large numbers if the blood of the internal organs could be examined.

Golgi thus sketched the life history of the hæmatozoon, and established a relationship between its reproductive processes and the clinical phenomena.

Now comes the question: Does the hæmatozoon cause the disease or is it an accidental accompaniment? Let us apply it to the ordinary criteria of a pathogenic microbe, as given by Fagge and Pye-Smith. The only one of these which it fails to fulfil is the fifth, namely, that on the introduction of a pure cultivation of the organism into an animal the disease must be reproduced.

It must be confessed that this, the crucial test, is at present wanting; firstly, because no animal susceptible to ague, with the doubtful exception of the pigeon, has yet been found; and, secondly, because all attempts at cultivating the organism outside the body have entirely failed. But strong indirect evidence that the hæmatozoon is pathogenic is found in the facts that spore formation coincides with the onset of the paroxysm; that the severity of the attack is generally proportionate to the number of parasites; that when the fever subsides, either of itself or under the action of quinine, the parasites disappear. Besides, such a supposition explains some of the symptoms in a very simple manner, especially the melanæmia, which had always been a puzzle to pathologists; and I think the evidence for it is convincing, if not conclusive.

The differences between the various forms of malarial fever, for instance, between a typical quartan and a typical quotidian are so marked, that the question arises whether all forms are due to the same variety of parasite.

Trousseau noticed that in the town of Tours only tertian fevers occurred, and that cases of quartan fever in Tours were always imported from without, generally from the neighbouring town of Saumur. He says, "The type seems to much more nearly approach the nature of the miasma, or more precisely of the locality which it infects, than the inherent conditions of the individual who suffers from its attacks."

Laveran, however, maintains that there is only a single organism, which is polymorphic, *i.e.*, may take on any of the varied forms previously described; and that the differences in the type of fever mainly depend on peculiarities in the individual attacked. This opinion is based chiefly on his inability to discover any association between a particular form of organism and a particular type of fever, and on the not unusual transformation of one type of fever into another, for instance, of a quotidian into a tertian during the course of a case, under circumstances which preclude fresh infection from without.

On the other hand, most Italian observers agree that the different forms of fever are characterized by different parasites. They divide malarial fevers into:—

a. Mild or spring fevers, never fatal, and almost always intermittent.

b. Severe or summer-autumn fevers which may be intermittent, or remittent, or continuous; and often present severe or fatal symptoms, delirium, coma, collapse, etc.

The spring fevers have been investigated by Golgi, at Pavia, where the fevers are mostly of a mild and regular type. Golgi's clinical material was thus much more favourable than that of Laveran in Algiers, where the fevers are severe and complex and their type difficult to distinguish, and this may account for the difference in their respective conclusions. Golgi says that the spring fevers are due to either (*a*) the spring tertian, or (*b*) the spring quartan parasite.

The common form of both kinds of parasite is the amœboid form with spore formation; flagella may occur in the quartan, but are commoner in the tertian parasite; crescentic bodies do not occur in spring fevers at all.

The amœboid form of the tertian parasite shows greater activity than the quartan amœba. Thus, it completes its life-cycle in 48 instead of 72 hours, it shows more active amœboid movement, it forms 15 to 20 spores, while the quartan amœba forms 6 to 12, and its spores are smaller, and, unlike quartan spores, show no nucleolus in the unstained condition.

In typical spring tertian fever a *single generation* of tertian parasites is always found; in other words, all the parasites seen are at about the same stage of development, and this explains the regularity of the fever. In a typical quartan a single generation of quartan parasites is found.

In spring quotidian fever either the tertian or the quartan parasite occurs; there is no special parasite for this form of fever. If the tertian parasite is seen, there are some fully-developed forms and others only half-developed; two generations are, in fact, present, sporing successively at intervals of twenty-four hours, and so causing daily attacks of fever. Mannaberg confirms the statement that two generations of parasites can be made out by the microscope in these cases. In quotidian fevers, due to the quartan parasites, Golgi says that three generations are present, separated from one another in their development by intervals of twenty-four hours.

Shortly stated, every spring quotidian fever, according to Golgi, is either a double tertian or a triple quartan. Quotidians are sometimes clinically recognizable as double tertians, the paroxysms on the odd days resembling one another, as do those on the even days; while the odd series differs from the even series in degree of pyrexia or hour of onset.

If we suppose two or more generations of tertian parasites sporing at irregular intervals, it is evident that an irregular fever would be produced. Now, quotidian spring fevers are very common and irregular, spring fevers comparatively rare, and the weak point of Golgi's theory as to spring quotidians is that he does not attempt to explain why one generation should, as a rule, lag behind the other by exactly one day.

Some support has been given to Golgi's view that tertian and quartan fevers are due to distinct parasites by the results of certain inoculation experiments in Italy. The method was to inject into the veins of persons in whom there was no malarial history a few c.c. of blood from patients with various forms of ague. Of seven patients injected with the blood of subjects of quartan fever, five developed quartan and two irregular fever. Of seven inoculated from patients with tertian fever, five developed tertian and two quotidian (? double tertian) fever. The average incubation-period was ten days.

The development of quotidian fever in a person inoculated from a patient with tertian fever may be plausibly accounted for by supposing that some of the parasites injected became retarded in their development, and thus a double tertian results; or the fever may become irregular from a similar cause. The only transformation that would be fatal to Golgi's theory is that of a tertian into a quartan, or *vicê versâ*, and such a change did not occur. Besides, no temperature-chart showing such a change of type in the course of a case has yet been published, although Laveran has recorded two doubtful cases.

The parasites of the severe summer-autumn, or malignant fevers, have been studied chiefly at Rome by Marchiafava and others. Perhaps the most important point to notice is that the crescentric bodies are peculiar to the summer-autumn fevers, and never occur in the spring fevers. Laveran is almost alone in denying this. The crescents are generally first seen about the eighth day of the fever; they persist when the fever subsides and other forms of parasite disappear, and are thought to be the cause of the relapses which are apt to occur in this type of fever without fresh exposure to infection. It seems that they can remain encysted for months, and then break up into spores, which cause a new attack of fever and develope into the amœboid forms once more.

The amœboid bodies in malignant fevers are small and active, and differ from the amœbæ of the spring fevers in forming very small spores in an irregular manner when they have reached such a size as to occupy about half the blood corpuscle. Flagella are seen occasionally in this as in all other forms of malarial fever.

Two varieties of malignant or crescent forming parasite are described, causing respectively, when a single generation is present, quotidian and tertian fever, while many generations of either cause irregular, remittent, or continued fever. The differences between these two varieties are small and unimportant.

The importance of the differentiation of the various forms of parasite is chiefly this: that malignant fevers may run a deceptively mild course at first, and that in such a case the discovery of large numbers of small crescent-forming parasites enables the physician to foresee danger, and to adopt correspondingly vigorous treatment.

The discovery that malaria is due to a protozoon has thrown light on some of the symptoms. The paroxysm is now looked upon as a protozoal sepsis (just as ordinary septicæmia is a bacterial sepsis), due to the setting free of poisonous products during spore-formation.

Apart from the paroxysm, anæmia and melanæmia are the most striking symptoms of malarial fever. The anæmia is a simple anæmia, severe and rapidly developed; a single malignant paroxysm may reduce the red corpuscles by twenty-five per cent. Since Laveran's discovery, its explanation is as obvious as that of the anæmia following post-partum hæmorrhage—the red corpuscles are eaten up by the hæmatozoa.

The granules of pigment which the parasite accumulates as it grows are the fæcal residue of this process of digestion, and when the mature parasite breaks up into spores, the melanin-granules contained in it are set free in the blood to be scavenged by the leucocytes, large numbers of which may be seen loaded with melanin just after a paroxysm. The presence of these granules in the blood and tissues constitutes melanæmia, a symptom peculiar to, and nearly constant in malarial fevers, and one which has long been known, in its severer degrees, as giving rise to a brownish or slaty discoloration of the viscera, especially the brain.

In patients dying from the comatose forms of malignant fevers, Bignami has found the cerebral capillaries blocked with masses of infested blood corpuscles, free

parasites, and spores; although comparatively few parasites could be seen in the blood generally. The infested corpuscles seem to be unnaturally adhesive, and the smallness of the brain capillaries favours their arrest. Bignami considers that the coma and other cerebral symptoms are not due, at any rate entirely, to a toxin, but to this mechanical obstruction to the brain-circulation, or to the capillary hæmorrhages which result from it.

In the gastro-intestinal or choleraic form of malarial fever, similar embolism of the capillaries of the stomach and intestines has been found.

It is an interesting question whether malaria can cause cirrhosis of the liver. There seems a general belief that it does so, though rarely, but owing to the great difficulty of excluding alcoholism, the evidence is very weak. Laveran, out of a large number of autopsies on malarial cases, only records two in which a cirrhotic liver was found. In one of these there is no mention of alcohol in the history of the case, which therefore has little value; in the other, that of a Mohammedan, who died with symptoms of cirrhosis and malarial cachexia, it is stated, "The patient observes his religion and uses no alcohol." This is the only unequivocal case I have been able to find, and even this rests entirely on the history. In spite of the belief of Laveran, Osler, Crosse and others, that malaria may cause cirrhosis, the opinion expressed by Fagge and Pye-Smith that probably it does not act alone seems quite justified by lack of evidence to the contrary.

The discovery of the nature of malaria cannot lead to any great improvement in treatment, because a specific for ague has long been known in quinine, but it explains the mode of action of the drug.

In 1867, Binz found that quinine is fatal to infusoria, even in very dilute solutions. It is more poisonous to these low animal organisms than even strychnine or morphine. Binz saw sweet-water amœba rolling themselves together as if tetanized in a 1 in 50,000 solution of neutral hydrochlorate of quinine. He made the lucky guess that malaria was due to a low form of organism, and that quinine acted by killing the organism.

By examining the blood of patients with spring tertian and quartan fevers at short intervals, after quinine has been given in a large dose, the following facts have been made out. Three hours after giving quinine, the amœboid movements slacken after a previous increase in activity; six hours after the dose of quinine, the number of parasites has diminished, and some of the remaining ones have broken up, while others are distended and dropsical. The nucleoli no longer stain with methylene blue. In twenty-four hours, no parasites can be found in the blood. The parasites, which are ready to form spores when quinine is given, complete their spore-formation in an apparently normal way, but the young amœboid forms, which should result from the spores, do not make their appearance within the corpuscles. The inference is that the spores are killed, and Golgi states that quinine is more deadly to the spores than to the parasite at any other stage of development, probably because they are not snugly sheltered in the blood corpuscles. Hence, he says, the time at which a given dose of quinine is most effective in intermittent fevers is five or six hours before the expected paroxysm. The oncoming paroxysm will not be prevented, since spore-formation takes place as usual in spite of the quinine, but the blood will attain its maximum strength as a solution of quinine just when the spores are set free, and thus, in favourable cases, if a large dose has been given, all the spores will be killed, and there will be no subsequent attack of fever. Large doses of quinine given daily are more effective than the same amount given in small doses, since if the drug is given in small doses the blood never contains much quinine at a time, and has only a feeble toxic effect on the parasites. Quinine, then, cures ague, as sulphur cures itch, by killing the parasites which cause the disease.

A few words may be said as to the method of examining the blood for parasites. A good sixth is a sufficiently high power, though a twelfth is preferable. Each slide should be examined for half-an-hour before the search is given up. Clean the slide and cover-glass most carefully with water or potash, and then with absolute alcohol. Wash the patient's finger first with ether, and then with absolute alcohol; when the finger is dry, prick it, wipe off completely the first drop of blood, then, when another drop, the size of a pin's head, has appeared, dab the cover-glass on it, and lower the latter carefully upon the slide. If perfect cleanliness has been observed, the layer of blood will spread out so thinly, that all the corpuscles will be seen on the flat, a condition essential for the examination. Staining is unnecessary.

Laveran's discovery enables a certain diagnosis to be made between malaria and the various febrile states that imitate it, or which it imitates. The finding of a single crescent, or flagellate body, or by a skilled observer, of a single amœboid parasite, settles the question beyond a doubt. "To be able," says Osler, "everywhere and under all circumstances to differentiate between malaria and other forms of fever is one of the most important advances which has been made of late years in practical medicine."

It seems likely that, within the next few years, other diseases may be proved to be due to protozoa. They, or bodies resembling them, have been found in connection with dysentery cancer, and cow-pox. Ruffer even suggests that syphilis, which has so long puzzled the bacteriologists, might profitably be investigated under the assumption that it is due to a protozoon; and in about ten years' time I suppose one may expect, somewhere down in the country, to read in the GAZETTE that the new protozoal laboratory has just been opened at Guy's.

In conclusion, I should like to express my thanks, and may I venture to say, those of the Society also, to Dr. Patrick Manson, for the beautiful specimens of the *hæmatozoon malariæ* which are on the table, and which Mr. Peters was kind enough to borrow for the occasion from Dr. Manson. For the specimen of hæmatozoa in the pigeon I have to thank Dr. Washbourn.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

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Guy's Hospital Gazette,

JANUARY 26, 1895.

Non-Ulcerative Colitis.

TWO CLINICAL LECTURES BY DR. HALE WHITE.

LECTURE II.—MEMBRANOUS COLITIS.

GENTLEMEN,—In the first place, let me tell you that the two patients in John ward suffering from colitis, who formed the subject of last lecture, are both improving very considerably. The only treatment has been rest in bed, and a milk diet.

The Clinical wards are emptier than I have ever known them, so I do not think we can do better than continue the subject of colitis, and I propose that we should to-day consider a rather rare condition, commonly called membranous colitis. You will find, as we go on, that there are several varieties of it, and you must particularly remember tha this term, when used during the patient's life, designates a form of colitis quite different from that which is in the post-mortem room commonly spoken of as membranous colitis. The reason is, that the last mentioned variety shows, during life, hardly any symptoms by which it can be recognised, while, on the other hand, the variety which is easy of recognition during life very rarely kills the patient.

Let us first consider the membranous colitis that is recognised during life, and I am induced to bring the subject before you, because I have recently seen a fatal case of it.

The patient, a man aged 62, had lived in Barbadoes, and came to England early in July last, because he was out of health. He placed himself under the care of Mr. F. K. Holman, to whom I am indebted for many notes about him. He was an Englishman, and he had always been thin, of a very dark complexion, of an exceedingly nervous temperament, and always had a poor appetite. All we could gather was that he had been for some time getting much weaker, that his bowels had been sometimes constipated, sometimes relaxed, that he had eaten hardly any food, and that he had been taking small doses of arsenious acid.

When seen on his arrival he was excessively weak, his temperature was raised a little, but it soon became normal. His bowels were constipated, but when relieved the motions contained much bright blood and great membranous shreds—varying from a mere fragment to a foot in length. He frequently vomited. With rest in bed, careful diet, and bismuth instead of arsenic, he gradually improved, and was able to go out for a drive by the end of September. All this time the bowels were irregular—sometimes open thrice a day, sometimes not at all, but the motions nearly always had with the fæcal matter a quantity of blood and many pieces of an opaque white membrane, about the colour and thickness of pieces of a tape-worm. This was examined microscopically and found to consist of collections of epithelial cells embedded in a structureless material. I first saw him in October, and the day before I saw him he passed membranes for the last time. He was then thin, very dark all over, especially about the nipples, genitals and perinæum. The tint was such as would be produced by long exposure to the sun. The tongue was slightly furred; the heart, lungs, throat, eyes, abdomen and rectum all seemed normal, and so did the urine, except that occasionally it contained much uric acid gravel.

The motion I saw contained about five ounces of fluid blood and hardly any fæcal matter. He was very dull, listless, apathetic and morose, taking little or no interest in his condition. It was only with the greatest difficulty that he could be got to eat a little slop diet. The passage of blood and mucus instead of actual membrane continued at intervals; he refused his food, and after a time returned enemata. He was occasionally sick, and in spite of every attempt to keep up his strength, he gradually got weaker, and died at the end of November. At the post-mortem, the whole body was absolutely healthy, except that the colon was thin and atrophied, and here and there showed one or two patches of congestion.

Now, perhaps you will say that in this case, the passage of membranes, mucus and bright blood in the bowel rendered the diagnosis easy, but it is altogether so exceptional for sufferers from membranous colitis to succumb, that as the patient was so ill that he was likely to die, we had several other things to consider, because it was just possible he might have had some other disease as well as membranous colitis, although this was very unlikely, for usually the sufferers from membranous colitis, as recognised at the bed-side, have no other organic disease. The dark colour of this patient suggested Addison's disease, but the tint was not quite that usually seen in this malady, nor was it the colour commonly seen in pernicious anæmia, although you will remember a patient in Stephen suffering from this disease who was very dark. Then, too, our present patient did not pass dark urine, nor had he any retinal hæmorrhages. We had no indication that he was suffering from repeated attacks of ague, malignant disease, or phthisis, all common causes for anæmia, with some darkening of the skin; nor could we make out that he was suffering from syphilis or lead poisoning. It was suggested, as he had come from abroad, that possibly he was suffering from the anæmia due to anchylostomum duodenale, but loss of blood from the bowels and diarrhœa are not the symptoms produced by this parasite, and the post-mortem examination showed that we were correct in not diagnosing any of these conditions.

This variety of membranous colitis, which we so easily recognize during life, may with advantage be called dyspeptic membranous colitis, for the subjects of it always suffer considerably from indigestion. It is much commoner in women than in men, is more often met with in private than in hospital practice, and is hardly ever seen in children. Picture to yourself a thin dyspeptic, somewhat anæmic woman, with a poor appetite, liable to suffer from the cold, of a depressed turn of mind, prone to constipation, and afflicted from time to time with exacerbations of her depression and dyspepsia, during which exacerbations she passes membranes and blood from the bowels, and you will have a good conception of dyspeptic membranous colitis. Sufferers from it rarely have buoyant spirits; they take a gloomy view of life, and exaggerate the importance of trifles. During an exacerbation these mental symptoms also become more marked; the patient complains of weariness; the tongue is furred; there is much griping pain in the region of the colon, usually some time after food; flatulence is troublesome, and there may be nausea, or even vomiting. After this state of things has gone on for a few days, membranes, or "skins," as the patient often calls them, are passed per rectum, usually with very little fæces, but sometimes with much blood. In a mild case this continues for a week, and then the patient is gradually restored to her usual health; but it may go on for months, or even years. Sometimes there is absolutely no fæcal matter in a motion, and occasionally the membranes are replaced by mucus. These membranes are of a whitish or yellowish grey colour, of about the consistence and thickness of a diphtheritic membrane. Occasionally a complete membranous tubular cast of the intestine is passed, which, as in our case, may be even a foot or more in length, but it is more common to meet with broken pieces and shreds. They may be stained a little by fæcal matter, and fæces may be found in the interior of the tube which may be of sufficient consistency to permit of its being held up. The end of the tube may be well defined or it may shade off into a gelatinous material. The broken pieces and shreds are occasionally rolled up into a solid ball. The microscope shows that the membranes are composed of a nearly transparent material in which lie embedded a number of fatty epithelial cells, which are clearly the intestinal epithelial cells. On the inner surface, little pits may be seen which are obviously the mouths of Lieberkühns follicles, and the epithelial cells may be seen grouped around them. In addition, a few small cells, fragments of fæces, and a few phosphatic crystals are often found in the membrane, which chemically consists of albumin.

These cases vary very much in severity. One patient I see occasionally, has an attack lasting about a week once a year, in the intervals she has fair health; on the other hand, many patients pass these membranes for months, or

even very many years, and all the while are perfectly wretched, owing to the chronic dyspepsia from which they suffer.

With regard to treatment, no drug is known to be of any great service. Your patient must keep herself in the best general health possible. She must take outdoor exercise, especially of such a kind as will employ the mind as well as the body. She must eat plenty of food, and should take all ordinary plain varieties. You will have much difficulty with this, for these patients usually declare they cannot eat this, and they cannot eat that, until at last there is hardly anything they will touch, and they half starve themselves. In diet, as in most other things, it is usually bad, not only for the mind but also for the body, to be fastidious and eccentric. Your patient should not sit up late, the meals should be at regular intervals, and should be made as tempting as possible. She must not be idle, above everything, she must find some occupation that will take her out of herself. Purgatives must be avoided, and whether or not she thinks the bowels will be open, the patient should go to the water-closet at the same time every morning. During an attack of the passage of membranes no purgative should on any account be given by the mouth. If the griping pain is excessive, an injection of glycerine or warm oil may be employed. In an extremely severe attack, rest in bed, hot fomentations and morphia subcutaneously may be necessary, but, if possible, avoid opiates, for they increase the constipation, and these people are often just those who might yield to the temptation to become habitual morphia-takers. Often more good is done by a good bracing holiday than by anything else. Some authors attach much importance in severe cases to washing out the bowel as high up as is possible from the rectum with boracic acid lotion, and it has been suggested that in intractable cases in which life is a misery it might be justifiable to open the colon in the right loin, to give it perfect rest by allowing the fæces to pass through the artificial anus, and to wash it out from this opening to the anus with boracic acid lotion every day.

We will now pass on to that form of membranous colitis which is due either to direct irritation or is associated with some severe disease. There are the following varieties of this form, none of which are recognised during life, for the patient probably does not live long enough for any membrane to become detached and passed during life.

(1) That due to direct injury. Here is a specimen from the museum showing a granular membrane on the inner surface of the colon of a boy who died three days after a cart-wheel had passed over the abdomen. Here is another showing membranous colitis in a woman who had swallowed a quantity of duck-shot with the object of reducing a strangulated hernia. This one is an example due to the swallowing of sulphuric acid, and this is due to swallowing corrosive sublimate. Membranous colitis due to this is particularly interesting, for Virchow and Liebreich have shown that poisoning by mercury, either rubbed into the skin, given subcutaneously or as a vaginal douche, may lead to a membranous colitis, no doubt because an irritating mercurial compound is excreted by the colon, and in one specimen we have of membranous colitis due to white precipitate taken by the mouth there was membranous inflammation of the vagina.

(2) Septic membranous colitis: This is a definite condition, and like some other pyæmic processes, cases occur in groups. Thus, during the years 1891, 1892 and 1893, seven cases occurred in our post-mortem room; there had not been a case for many years previously. Here is a specimen from one of the seven cases. The patient died from pyæmia, following upon necrosis of the thyroid cartilage. If we put together the cases of simple septic colitis we considered in the last lecture and these cases of membranous septic colitis, it is interesting to note that in only two was there any pus in the joints. Of the seven membranous cases, five were women, and in two the kidneys were affected. The membrane usually had a distinct line of demarcation, and the membranous areas might be separated by healthy mucous membrane. The histories of some of the cases appeared to indicate that the membrane might form in seven or eight days.

(3) Membranous colitis may occur in Bright's disease. I cannot show you an example of this, but you will find it mentioned in Wilks and Moxon.

(4) It is also described as in certain rare conditions complicating acute pneumonia. You will not forget that in the last lecture we showed that simple colitis also might be associated with direct irritation, septic processes, Bright's disease and pneumonia.

It is not known for certain whether the diphtheria bacillus ever produces a membranous colitis.

Hospital News.

In the Medical Wards.

The case under Dr. Pye-Smith, Mary 29, reported on page 5 in the last number, is one of "Hereditary Ataxy."

Since the date of our last issue, the left side of the chest of the patient under Dr. Taylor, G. W., Stephen 9, reported on page 6, has been explored, and fluid of a thick chocolate colour found. On microscopical examination it was seen to consist of cholesterin crystals, fat-cells and granular débris.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY 3, 15. Aortic and mitral regurgitation.
8, 9, 30. Chlorosis.
12, 27. Mitral stenosis and regurgitation.
18, 46. Mitral stenosis.
42. Ascites. Morbus cordis.

PHILIP 25. Mitral stenosis and regurgitation. Aortic regurgitation.
33. Mitral stenosis and regurgitation. Tricuspid regurgitation.

STEPHEN 6. Mitral and tricuspid regurgitation. ? Aortic stenosis.
16. Aortic and mitral regurgitation.
21. Mitral stenosis and regurgitation.
40. Aortic stenosis and regurgitation. Mitral regurgitation.

Nervous System.

MARY 1, 24, 26. Exophthalmic goître.
11, 19. Chorea.
29. Friedreich's disease.
33. Melancholia.
43. Hysterical paraplegia.

PHILIP 3. Cerebral tumour.
8. Cerebral syphilis. Amnesia.
14. Cerebellar tumour. Fits.
22, 36. Paraplegia. Syphilitic myelitis.
30. Double facial paralysis. Syphilis.

STEPHEN 12. Cerebral tumour. Optic atrophy.
17. Chronic myelitis. Spastic paraplegia.
36. Right hemiplegia. Aphasia.
38. Myelitis.

Alimentary System and Abdomen.

MARY 13. Tuberculous peritonitis. Laparotomy.
14. ? Carcinoma of stomach.
16. Hæmatemesis. Gastric pain.
25. Pelvic cellulitis.
37. Chronic constipation.
38. Œsophageal obstruction. Phthisis.

PHILIP 15. Gall-stones. Right hemiplegia.
18. Jaundice. Carcinoma of liver.
24. Ascites. Cirrhosis of liver.

STEPHEN 5. Abdominal pain.
10. Lardaceous spleen.
14. Abdominal pain. ? Gastric ulcer.

Genito-Urinary System.

MARY 6. Uræmia. Uræmic rash.
22. Chronic interstitial nephritis. Hypertrophied and dilated heart.
40. Renal tumour. Pyonephrosis.

PHILIP 16. Hydronephrosis.
27. Acute nephritis. Bronchitis.

STEPHEN 11, 19. Diabetes mellitus.
15. Perityphlitis.
18, 35. Chronic tubal nephritis.

Respiratory System.

MARY 4, 5. Bronchitis.
7. Emphysema. ? Phthisis.
17. Phthisis. Anæmia.
28, 31. Pneumonia.

PHILIP 1. Pleuritic effusion.
28. Bronchitis.

STEPHEN 3, 20. Empyema.
9. Chronic pleuritic effusion.
33. Abductor paralysis of vocal cords. Tracheotomy. Locomotor ataxy.

Miscellaneous.

MARY 41. Tonsilitis. Enlarged cervical glands.

PHILIP 29. Syphilitic arthritis.
39. Œdema of legs. Delirium.

STEPHEN 8. Tuberculous arthritis.
29. Acute alcoholism.
31. Tetanus.

CASE UNDER DR. PYE-SMITH.

MARY.

28. M. A. C., æt. 17. Admitted January 5th for "pains all over the body." Patient has several brothers and sisters alive and healthy. She is a general servant, and has suffered from severe headache and throbbing pains in the head all her life, these being worse in the summer. Three weeks ago patient experienced a feeling of weariness and inability to do her work, which remained day after day. A week previous to admission she complained of feeling very cold even when in bed. On Friday, January 4th, severe pains in the back of the neck, shoulders, sacral region, and lower part of abdomen, accompanied by sickness, were experienced. In the evening patient drank a quartern of gin, as she "thought it would do her cold good." On Saturday she remained in bed during the morning, and on getting up later, whilst sitting in a chair she became unconscious.

On admission.—Patient has a dark complexion and dark rings around both eyes. When in bed she preferred to lie on her side with her body inclined to the prone position and the legs drawn up. She was obviously very ill. Temperature 103. Chest normal, without any physical signs. Impulse of heart in the fourth left intercostal space, an inch and a half inside nipple line.

Lips dry and tongue covered with a thick white fur, except at tip. Tonsils enlarged. The bowels had been confined for two days previous to admission. Abdomen not distended or tender upon palpation. *Urine* acid sp. gr. 1034. Urea 4 per cent. In appearance urine was thick, with a large deposit of urates. The menstrual periods are regular.

7th. Patient very sick, with pain in the head. Milk diet. Patient is very drowsy and stupid.

8th. Patient less drowsy to-day; still complaining of pain in the head.

9th. Temperature fallen to subnormal. Patient is brighter and more cheerful.

12th. Patient free from all pain and feeling very hungry. Bowels opened. Tongue clean, and patient is feeling quite well.

The following diagnoses were at first discussed:—Typhoid, meningitis, influenza, and rheumatism. However, when the temperature became normal, it was thought to have been a case of "influenza."

CASE UNDER DR. TAYLOR.

STEPHEN.

10. A. F., æt. 63, clerk. Admitted for swelling in left hypochondriac region, accompanied by shortness of breath.

Previous history. Attack of gout in left foot 41 years ago; since then frequent attacks in various joints, from one to six per annum. In 1865, had gonorrhœa, followed by stricture. In June, 1885, patient was operated on for pyonephrosis, consequent on stricture and cystitis. Patient still wears drainage-tube in left lumbar region, from which small amounts of pus and urine escape. From this time until May, 1894, patient's health continued very fair, when he was seized with hemiplegia of the left side, accompanied by partial loss of speech; attack lasted six weeks; patient has had no recurrence, and feels no effects therefrom. Five weeks ago patient noticed his breath getting very short, and he had pain over the tumour, and was eventually admitted.

Condition on admission. Patient is fairly well nourished, although he has lost flesh lately. Some well-marked tophi on each pinna, and over the olecranon process of each elbow. Abdomen distended; edges of recti separated; dulness in flanks and iliac regions; umbilicus protruded; liver slightly enlarged. On palpation a somewhat hard tumour can be felt on the left side, the upper margin extending beneath ribs and consequently cannot be made out. The tumour extends to within one and a half inch of median line of abdomen, and to within one inch of a line drawn horizontally through umbilicus, although the inner margin is somewhat indistinct.

Urine.—Pale, yellow colour, very turbid, with small amount of reddish-yellow deposit, alkaline, sp. gr. 1016, contains albumin and pus, and large numbers of phosphatic crystals can be made out under the microscope; amounts vary from 32 to 56 ounces per twenty-four hours.

Treatment.—16th.—Pil. Diuret. cum Hydrarg. grs. v t.d.s.

19th.—Pot. Iod. grs. v.
Mist. Ol. Morrh. et Ferri ʒj. t.d.s. p.c.

The tumour does not seem to alter; discharge from side has diminished. Urine has lost most of its offensive odour, and contains much less pus, and the abdomen is very much less distended, there now being apparently no ascites.

Mr. Howse was called in to see the patient, and on examining him, agreed with the diagnosis already made by Dr. Taylor, viz., lardaceous spleen. Further, Mr. Howse did not think operative treatment would be advisable, as at the time of the operation, ten years ago, the kidney and neighbouring structures were matted together by dense adhesions.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ACCIDENT	4.	Stab penetrating abdominal wall. No injury to viscera.
	7.	Diffused hæmatoma of cord, due to kick by horse.
	29.	Compound comminuted fracture of tibia and fibula. Amputation through thigh.
	32.	Compound fracture, radius and ulna.
NAAMAN	2.	Badly-united femur. 2½ inches shortening.
	13.	Sarcoma of testicle.
	16.	Congenital syphilis. Multiple nodes.
	19.	Epithelioma of lip.
LUKE	5.	Acute hydrocele, following operation for varicocele.
	10.	Stricture of rectum.
	19.	Tubercular disease of wrist-joint.
CHARITY	7.	Chronic intestinal obstruction.
	9.	Old hip disease.
	11.	Adeno-fibroma of breast.
	13.	Cystic adeno-sarcoma of breast.
	Cot.	Prolapsus ani.

CASE UNDER MR. DAVIES-COLLEY.

LYDIA	18.	Webbing of fingers, resulting from burn. Plastic operation.

CASES UNDER MR. LUCAS.

LYDIA	5.	Spinal caries. Mid-dorsal region.
	Cot.	Congenital talipes varus.
	Cot.	Rachitis. Cranio-tabes. Curvature of spine, etc.
JOB	5.	Tubercular ankle-joint. Excision by transverse anterior incision. Tendons divided and sutured.
	18.	Double tubercular testicle with tubercular nodule in cord of right side. Removal of right testicle.

JOB	25.	Perforating ulcers on feet. No cause evident. Amputation of great toe, with ulcer perforating to interphalangeal joint. Previous operation.
	—.	Hydrocele of tunica vaginalis.

CASES UNDER MR. GOLDING-BIRD.

MARTHA	3.	Cut extensor tendon.
	5.	Large lipoma on shoulder. Removal. (See photograph in Report.)
	18.	Congenital syphilis. Thickening of tibiæ, etc. Enlargements of liver and spleen.
LAZARUS	5.	Blow on abdominal wall. Rupture of muscle, with formation of hernia. Operation. Bowel (transverse colon) reduced and rent in abdominal wall sutured.
	6.	Ankylosis of knee, following rheumatic fever.
	11.	Varicocele. Goître.
	13.	Acute hydrocele. Incision.
	14.	Double cystic epididymis (encysted hydrocele of testicle).
	18.	? Sacro-iliac disease.
	22.	Ankylosis of hip, following rheumatic fever.

CASES UNDER MR. LANE.

JOB	12 & 14.	Loose semilunar cartilage. Removal in each case.

De Examinationibus II.

IN our first article upon this interesting subject, we endeavoured to act upon the obvious corollary of the old saying: "De Mortuis nil nisi bonum,"—viz., "De vivis nil nisi optimum." We insisted upon the importance of previous knowledge, or of rapid recognition of the personal equation of the examiner. There are few conditions in which there is a greater need of this perception than in what we may call the simulation of the idiot. This method consists in refusing to recognise, *e.g.*, a particular specimen—for it is more applicable in matters pathologoid—and in giving it some entirely different name, the difference being directly proportional in amount to the astuteness of the examiner in question. One examiner will swallow a most ridiculous bungle, whilst another feels that his family pride has received a jar—vulgariter, that he is being "got at." To succeed well, the false ascription must be said without any hesitation, and with all the conviction that the histrionic talent of the candidate can muster.

A classical gross paraphrase of this method is to be found in the case of the well-known Irish student, whose words concerning the first specimen shown him were: "Bedad, and I think it is a fatus!" The examiner was somewhat astounded at this new nomenclature for a sarcoma, and passed on to some other subject, after a short survey of the ethics of the matter. But the Irish nature was too bold, for, at the second specimen, he said: "Begorra, and I think it can be nothing at all but a fatus." Naturally the examiner's patience was tried—tried to the uttermost, and—found wanting. But that was the candidate's own folly. Any tell-tale pitcher that tells his tales too oft, will some day come to grief, if, indeed, he is not considered cracked. It is truly remarkable how, in carefully selected cases, a candidate can avoid a given subject by an assumption of total ignorance. But, after giving some assumed name, it is usually well to go back a little upon his statement, and point out a detail or two, wherein the affair differs from a typical case. And this may sometimes be an opportunity for leading the examiner along a bye-path. But it must not be thought that only aberrant specimens are fit for such treatment. We have known quite typical ones so treated with perfect success. In our former essay we uttered a warning to the neophyte, and again we would repeat it. He must be prepared for emergencies, for a certain class of examiners do not refuse point blank at this form of fence, as do others, but return again and again to the same subject for a weary long while. Be it remembered, however, that, as a general rule, under such circumstances they do not think it worth while to ask any but the simplest questions; so let them be answered in the simplest of replies, if the subject is one that is to be avoided for any given reason.

There is another ruse that is not infrequently successful in attaining the goal of all examination candidates. This is called the "not guessing" principle. A frequent remark of a revered old teacher is, "Never guess! If you guess, you clearly show that you do not know two things—the one that which you guess, the other that which you should have said." Many examiners ask questions in which two alternatives are put forward. We hold that the second alternative should never be mentioned, except later if the candidate flies off at a tangent. If an examiner does thus infringe one of the primary axioms of "Examinology" and if, again, he hath a pleasing and genial look—one of the fat sort Shakespeare said that Julius Cæsar liked—it is usually safe simply to reply "I will not guess"—impressively, indeed, almost tragically. A pleasant smile and a hearty "Quite right! don't guess!" often leads on to no "mauvais quart d'heure."

Nor can any qualms of conscience arise from such and other perversions of and deviations from golden truth: for all tenements used as examination halls, rooms, hovels, etc., have a most perfect power of absolution. Thus it happens that, thoughtfully accomplished, the most astounding of lies, the most profound of hypocrisies and the most heartrending equivocations may be uttered with impunity.

Lastly, in case no further communications are written upon this subject, let the following aphorism be held in mind—never let an examiner be informed of all you know; and always let him be led to believe that you know more than you communicate to him. Δ.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Specialism in Medicine.

SIR,—Until I read in your issue of December 29th, the article, "Specialism in Medicine," signed by S. W. MacIlwaine, I, in my ignorance, fondly imagined I had joined the ranks of men whose mission in life is to alleviate human pain, and at the same time (in the practice of an honourable profession) enjoy some of the good things of life that by right belong to all those who honestly work for them.

The perusal of the article has, however, dispelled all such fond delusions, and I am now given to believe that the members of my profession have no more right to such a claim than any "tonsorial artist." Still, as Mr. MacIlwaine is of opinion that "specialism is the very essence of superficiality," such a mistake is, I suppose, pardonable.

He says "the great aim of medical education ought to be to produce men who can take case after case and say what the fundamental derangement is in each." Surely a most laudable ideal—and, were the "thoroughly good all-round men" able to compound for themselves some "elixir vitæ," that would enable them to prolong their lives indefinitely, no doubt such a result would be attainable.

Unfortunately, the messenger that brooks no denial always steps in at a most inconvenient time and carries away one man who, no doubt, had he lived longer, would have been such an authority on all human ailments that he could have dispensed entirely with that confirmation of diagnosis which our present race of "good all-round men" are often so anxious to have.

I have always been of opinion that in view of the brevity of human life, specialization was essential to a high standard of excellence in any department of work, and, speaking on behalf of my own profession, I will quote two of many cases that have strengthened my opinion.

CASE I.—A soldier in a military hospital suffered intense agony for days, caused by the diseased root of a bicuspid tooth. *Treatment.*—Poulticed on the *outside* of the face (almost the size of a small balloon), and sent out, after a pleasant variety of said poultice and pain, with the offending member *in situ* and the pleasant prospect of a future happy time.

CASE II.—Patient, a man. *Diagnosis.*—Diphtheria. *Treatment.*—Patient isolated. House turned inside out by sanitary authorities. *Result.*—Great expense and inconvenience, with no relief to sufferer. Fortunately, a "superficial specialist" in my own profession discovered that the tissues and adjacent inflammation were due to an impacted lower wisdom tooth, on the removal of which the patient speedily recovered.

Both these cases were in the hands of men who would have felt insulted if described other than "good all-round men," one of whom is well described in the words of the poet as—

> "Stiff in his opinions, often wrong,
> Everything by turns, and nothing long."

"To err is human," and a wise man has said we learn more from our failures than from our successes, but surely that exactitude of diagnosis to which most specialists are able to attain, is only possible to men who bring years of study and experience in their own department of work to bear upon the cases that come before them.

May I venture to remind the writer of the article that although criticism is always essential to the maintenance of a high standard of excellence, yet the governing bodies of our educating and examining centres are composed of men of experience and undoubted ability, who must have good reasons for encouraging specialization, at least until an immortal race of "thoroughly good all-round" men comes along.

—Yours faithfully,

FRANK H. CARPENTER.

Trinity Street, S.E.

A Case of Cæsarian Section—P.M.

ON the 5th instant, my attention was called to the following interesting incident, which I think is worthy of recording. Mr. J. B., junior (who, as joint partner in a large business, is constantly purchasing rabbits and killing the same for disposal), on December 27th, "dressed" a rabbit, and, to use his own words, said "that he found a 'bag' inside, which he carefully opened, and found four little ones in it. He cut the navel strings, but as they appeared lively he didn't like to destroy them; he accordingly wrapped them in cotton wool, placed them in a basket, took them home, and put them in the oven, wondering how he should feed them in the morning. As luck would have it, he found next morning that a black and white doe had littered down with four, he thereupon added three of the other progeny—two grey and one black—(for one had died during the night) to the bringing up of the foster mother." My curiosity was excited, and I asked to see the hutch and its contents; and, although late in the evening, I was shown this family. The owner found that the doe had destroyed two of her own young, and the black one out of the foster lot. The remaining four were lively; the grey ones were much smaller than the black and white. To-day (the 21st) I am informed that the "family" is progressing favourably.

W. WATSON.

Rochester.

Some Statistics

SHOWING THE RELATIVE LOSS FROM ALL CAUSES OF THE DIFFERENT PERMANENT TEETH.

At the suggestion of Mr. Maggs, and through the kindness of the Medical Superintendent (Dr. Perry), an analysis of the Registers of the Extraction of Teeth in the Dental Department of Guy's Hospital has been made. The record extends over a long period, and the total number of permanent teeth extracted was 30,012.

TABLE I.

TEETH.	NUMBER.	PERCENTAGE OF THE WHOLE NO.
1st Molars	10891	or 36·30
2nd Molars	5904	,, 19·68
2nd Bicuspids	4179	,, 13·93
1st Bicuspids	3212	,, 10·70
3rd Molars	2639	,, 8·76
Lateral Incisors	1202	,, 4·00
Canines...	1098	,, 3·66
Central Incisors	887	,, 2·95
Total	30,012	Total 99·98

TABLE II.

Showing the percentage of the different kinds of the Upper Teeth extracted.

TEETH.	NUMBER.	PERCENTAGE OF UPPER TEETH.
1st Molars	5259	or 32·04
2nd Bicuspids	2503	,, 15·24
2nd Molars	2415	,, 14·22
1st Bicuspids	2288	,, 13·87
3rd Molars	1317	,, 7·96
Lateral Incisors	1013	,, 6·17
Canines...	861	,, 5.24
Central Incisors	754	,, 4·10
Total	16,410	Total 99·84

TABLE III.

Showing the percentage of the different kinds of Lower Teeth extracted.

TEETH.	NUMBER.	PERCENTAGE OF LOWER TEETH.
1st Molars	5632	or 41·40
2nd Molars	3489	,, 25·63
2nd Bicuspids	1676	,, 12·32
3rd Molars	1322	,, 9·71
1st Bicuspids	924	,, 6·78
Canines	237	,, 1·74
Lateral Incisors	189	,, 1·38
Central	133	,, ·97
Total	13,602	Total 99·93

TABLE IV.

In order of frequency of Upper and Lower Teeth combined.

TEETH.	NUMBER.	PERCENTAGE OF TOTAL NUMBER EXTRACTED.
Lower 1st Molars	5632	or 18·765
Upper 1st Molars	5259	,, 17·409
Lower 2nd Molars	3489	,, 11·625
Upper 2nd Bicuspids ...	2503	,, 8·330
Upper 2nd Molars	2415	,, 8·046
Upper 1st Bicuspids ...	2288	,, 7·623
Lower 2nd Bicuspids ...	1676	,, 5·584
Lower 3rd Molars	1322	,, 4·404
Upper 3rd Molars	1317	,, 4·388
Upper Lateral Incisors ...	1013	,, 3·375
Lower 1st Bicuspids ...	924	,, 3·078
Upper Canines	861	,, 2·868
Upper Central Incisors ...	754	,, 2·512
Lower Canines	237	,, ·789
Lower Lateral Incisors ...	189	,, ·629
Lower Central Incisors ...	133	,, ·443
Total	30,012	Total 99·868

It is interesting to find that the published statistics by Sir John Tomes, as shown by the subjoined table, indicate the same relative frequency of the loss of the permanent teeth as at Guy's Hospital, although the total of Tomes' is 3000, as compared with our 30,012.

TABLE V.

Compared with Sir John Tomes' statistics.

	SIR JOHN TOMES.	PARE & WALLIS (deduced to 3001·2).
1st Molars ...	1124 or 37·46%	1089·1 or 36.30%
2nd Molars ...	637 ,, 21·23	590·4 ,, 19·68
2nd Bicuspids	434 ,, 14·46	417·9 ,, 13·90
1st Bicuspids ...	273 ,, 9·10	321·2 ,, 10·70
3rd Molars ...	265 ,, 8·83	263·9 ,, 8·79
Lateral Incisors	117 ,, 3·90	120·2 ,, 4·00
Canines ...	78 ,, 2·60	109·8 ,, 3·50
Central Incisors	72 ,, 2·40	88·7 ,, 2·95
Total	3000 99·98	Total 3001·2 99·82

The practical outcome of the study of these statistics is to impress upon the minds of dental students and practitioners that the first molars are those most liable to be lost early, and that their extraction in crowded mouths for regulation purposes is to be preferred, *cæteris paribus*.

It shows also that the second bicuspids are more liable to be lost early than the first, and hence the removal of the former is indicated. Again, the extremely low percentage of extraction of the lower incisor and canine teeth is manifest. The persistence of these teeth is well known to all engaged in the practice of dentistry, and is, no doubt, accounted for, to a large extent, by the fact that they are continuously bathed in saliva, which, being normally alkaline, neutralises any acid, produced by fermentation of food lodged between the teeth, or eructations from the stomach, and so prevents the disintegration of the enamel.

J. W. PARE.
HERBERT WALLIS.

A Case of Simple Depressed Fracture of the Skull.

OPERATION: RECOVERY.

HAVING read the very interesting report of a case by Mr. Lockhart Stephens in the issue of the GAZETTE of January 12th, I send notes of a case which happened to me rather more than two years ago, in the hope they may also be of interest. It took place at a country public-house some three miles distant.

On October 18th, 1892, the patient, a little girl four years old, was leaning out of a window at a height from the ground of about 18 feet, when she fell, striking her head on the way on a stone ledge about six feet below, and alighting on the vertex. This happened at 5 p.m. At 6 p.m. she was seen by my partner, Mr. A. E. Garrett. She was then unconscious, the left pupil larger than the right, and reacting sluggishly to light. She was said to have had two convulsions before being seen, in which the right side of the body moved. While being examined she had three convulsions, involving the right arm, right leg, and right side of face. On examination, a small scalp-wound not going down to the bone was found to the left of the occipital protuberance; an inch and a half behind and above the external auditory meatus was a simple depressed fracture easily admitting the tip of the forefinger—this was, presumably, caused by the fall on the stone ledge. The pulse was 80 and the respiration 16, the latter rather shallow. I saw her at 10 p.m. Since six o'clock she was said to have had two more convulsions, affecting the right side of the face and right arm and leg; she was in one of these for more than half an hour. She had been sick twice, and become rather more conscious. The respirations were 16, shallow. She moved when the wounds were manipulated.

The surroundings were unfavourable to an operation, but considering the condition of the child I decided to trephine at once. The room available was a sort of scullery, with the usual accompaniments of such a place, the table a small one, to cover which we could only obtain a not too clean blanket; the light was provided by tallow candles. A country woman volunteered to wash the sponges. Fortunately, we had plenty of perchloride tablets, and were not short of alembroth dressings.

Mr. Garrett giving chloroform, which was taken well, I shaved and aspeticised the left side of the head, and made an incision down to the bone, three inches in length downwards and forwards with its centre over the depression, and another downwards and backwards of similar length, thus exposing a depressed fracture of the equamous portion of the temporal bone about the size and shape of a small tea-spoon, and a simple fracture radiating from it above into the occipital bone, and downwards into the mastoid. With a medium-sized trephine a circle of bone was removed from the posterior side of the depression; the dura mater bulged up at once. The depressed bone was elevated, and a downwardly-projecting fragment snipped off. The respiration improved directly, becoming very much deeper and more easy.

The circle of bone removed was not replaced. Hæmorrhage was arrested, the pericranium brought together with a carbolised catgut suture, and the wound irrigated with Sol. Hyd. Perchlor. (1·1000). The skin-incisions were brought together with wire sutures, leaving the lower part open for drainage, dusted with iodoform and dressed with blue gauze. At the end of the operation the pulse was 116 and respiration 26. One-fifteenth grain of morphia with atropia was given an hour after the operation, as the child was restless.

Oct. 19th.—Patient quite comfortable; plays with toys and sits up in mother's lap; will not lie down. Bowels moved twice since the operation; sickness occurs whenever milk is given. Temperature normal. Potass. Brom. gr.ii. h.n.

22nd.—Pulse, 120; temperature, 98. Wound dressed, as the child seemed in pain; it looked perfectly healthy, and was already beginning to heal.

24th.—Temperature, 98·2. Child quite comfortable.

28th.—Wound dressed; all sutures removed except the "four-way" suture at the centre; healed well except at lower part.

Nov. 3rd.—Bandages removed, and the small granulating patch remaining unhealed dressed with blue gauze and strapping.

March 3rd, 1893.—The child was seen to-day; looking well and healthy; scar sound. The trephine-hole feels indistinct, and appears somewhat triangular to the finger.

The scar was examined about a year later, when the trephined spot could hardly be felt as a depression, and was quite firm.

Rickmansworth. H. W. WEBBER.

Appointments.

FEBRUARY, 1895.

Clerks to Anæsthetists.—Messrs. O. Beven, B. B. Ham, R. H. Hayes, H. A. Moffat, W. M. Price, P. E. Tresidder.

Externs.—Messrs. R. H. Ashwin, R. E. Delbruck, W. L. Garner, J. Hora, S. G. Layman, F. R. Proctor-Sims.

Dental Appointments.

FEBRUARY, 1895.

Dressers in the Gas Room.—Messrs. F. C. Beaumont, H. King, C. A. H. Keall, J. W. Lewis.

Dressers in the Ordinary Extraction Room.—Messrs. W. Briant, S. W. Cock, A. De Mierre, E. B. Dowsett, K. W. Goadby, N. H. Oliver.

Pass List, January, 1895.

Second Conjoint Examination.

ANATOMY AND PHYSIOLOGY.

Balderston, R. — Lincoln, C. H. S.
Denyer, S. E. — Nicholls, F. J.
Worts, C. C.

ANATOMY ONLY.

Lewis, L. H. — Longhurst, S. H.
Salmon, C. C. A.

PHYSIOLOGY ONLY.

Gibson, C. W. — Poole, C. C.
Mason, S. H. — Treusch, J. B. A.

First Conjoint Examination.

ELEMENTARY ANATOMY AND PHYSIOLOGY.

Allan, H. W. — Denyer, S. E.

ELEMENTARY ANATOMY ONLY.

Richardson, J. J. D.

MATERIA MEDICA AND PHARMACY.

Curtis, P. J. — Goodridge, W. L. T.
Evans, C. R. — Mason, S. H.
Thorpe, R. S.

Second Conjoint Examination.

(Regulations dated 1st January, 1892).

Walters, J. B. — Watt, J. G.

First Conjoint Examination.

(Regulations dated 1st January, 1892.)

CHEMISTRY AND PHYSICS.

Bent, V. T. C. — Michell, R.
Crawford, V. J. — Rodil, J. J.
De Coteau, J. T. — Row, E. R.
Featherstone, F. R. — Smith, A. Ayre.
Griffiths, D. R. T. — Sturdy, H. C.
Williams, N.

PRACTICAL PHARMACY.

Simpson, G. S.

ELEMENTARY BIOLOGY.

Batchelor, H. C. — Kirkman, A. H. B.
Carr, H. Brooks. — Lister-Kaye, A.
Westlake, B. B.

ELEMENTARY ANATOMY.

Dowsett, E. B. — Kelly, T. T.
Hope, W. B. — McLachlan, A. R.
Thomas, A. M.

From the Gazette's Special Pathologist.

ALL specimens — particularly those of solid tissues — should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled Immediate.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

H. G. A., NOTTINGHAM.—The sections of the prostate show an infiltration of its muscular substance with carcinoma of the cylindrical-celled type.

DR. F., OLDHAM.—There is no evidence of malignant disease in the fragments sent for examination. They consist of portions of the endometrium infiltrated with many inflammatory cells, and mingled with much blood-clot.

T. R. A., SHERBORNE.—Specific gravity 1012, slightly acid; trace of albumin, which is apparently due to pus-cells. There were no "casts" to be recognised. Bladder epithelium also present. No blood or sugar.

W. C. B., BOGNOR.—Tubercle bacilli present.

J. D. C., CHINGFORD.—No tubercle bacilli were found.

T. E. D. H., REIGATE.—A few tubercle bacilli were present.

W. L. W. M., HUDDERSFIELD.—Tubercle bacilli present.

C. D. M., BOURNEMOUTH. — No bacilli diphtheriæ present.

X., FAVERSHAM.—(*a*) No tubercle bacilli present. (*b*) No tubercle bacilli present.

C. B. B., GOLCAR.—No tubercle bacilli could be found.

A. C. B., DORKING.—No tubercle bacilli present.

G. S. P., MIDSOMER NORTON.—The growth is a typical scirrhus carcinoma of the breast, and shows evidences of rapid development.

E. R., SWANSEA.—The wall of the stomach is extensively invaded by a soft spheriodal-celled carcinoma. The growth is undergoing rapid degeneration; hence the cyst described was probably a softened secondary deposit of the growth outside the stomach.

PATHOLOGIST.

Passim.

THE management of this Journal would be greatly assisted if they might be allowed to re-acquire any copies of the GAZETTE of the 29th December last, for which our subscribers may have no further use. Those gentlemen whose subscriptions only commenced at the latter end of 1894 will perhaps kindly help us, and the Librarian is authorised to negotiate the surrender on mutual terms.

AT the next meeting—Pathological evening—of the Physical Society, which will be held on Saturday, the 2nd proximo, in the Library, Mr. Targett, we are glad to hear, has kindly promised to show some interesting pathological specimens by means of the lantern.

IN our account of the last Clinical evening of the Physical Society, we reported a case shown by Mr. Pendred as a "tumour of breast, with a very long history." We have been informed that a diagnosis of "sebaceous cyst of one of the glands of the nipple areola" was suggested, and that at the subsequent operation this proved to be correct.

THE Clinical wards have of late been singularly devoid of cases of interest. It is gratifying to hear that during the past week there has been a welcome change—from the point of view of the clinicals. Several cases have been admitted, which well deserved the attention bestowed upon them. Amongst others, there has been one of a man suffering with severe diabetes mellitus, culminating in coma, whilst another was that also of a man, who had signs and symptoms of acute pneumonia, rapidly followed by those of pleuritic effusion in the right chest, which, on exploration within forty-eight hours of the onset of the illness, proved to be purulent.

THE Residents propose, with the kind permission of the Treasurer, to hold their Annual Dance in the Court Room on Wednesday, February 20th. As the number of tickets for disposal will be strictly limited, application, in writing, should be made not later than February 6th, to one of the Residents. Gentlemen's tickets, 8s. 6d. each; Ladies', 6s. 6d. each.

TUESDAY morning's letters at the Counting House were of the usual kind, excepting one from a firm of solicitors in Lincoln's Inn, asking attendance upon them that day in reference to a donation to the Hospital. Sending for a cab—which by the way, had a large hole in the floor, and whose windows formerly, perhaps, pulled up and down—Mr. Williams faced the snowstorm. It was a cold journey there, but a warm one coming back, for in his purse he carried the munificent donation of £2,000, the gift of a lady towards the Hospital funds. Rumour says more journeys of a like character would be willingly undertaken, snowstorms and mouldy four-wheelers notwithstanding.

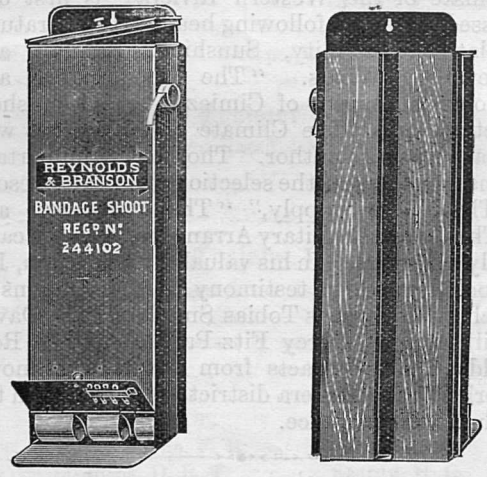
WE have read with more than a passing interest the excellent publication, "Cimiez: its Health and Climate," by Dr. Crook. The short work teems with points of interest, and we are sure will be found of much value to general practitioners in their choice of a health resort for the more wealthy of their patients. It will be remembered that the author has previously written an admirable treatise on "Margate as a Health Resort," and in his latest work Dr. Crook has grappled with the subject in an equally practical manner. The "General Climate of the Western Riviera" is first discussed under the following heads: Temperature, Relative Humidity, Sunshine, Rainfall and Prevailing Winds. "The Geographical and Geological Aspect of Cimiez" occupies a short section, and "The Climate of Cimiez" is well treated by the author. Those most important considerations in the selection of a health resort, "The Water Supply," "The Drainage," and "The General Sanitary Arrangements," are carefully criticised. In his valuable monograph, Dr. Crook has added testimony to the opinions of such authorities as Tobias Smollett, J. B. Davis, William Farr, Percy Fitz-Patrick, and S. Reynolds Hole, extracts from whose well-known works on the Riviera district are included in the volume under notice.

IT is so seldom that these columns are burdened with appeals to the philanthropy of our readers, that we feel considerable confidence in making the present one. RICHARD GREENHILL SILVERLOCK, aged 8 years, the son of an old Guy's man, who died at the early age of 28, is a candidate for election to the Royal Medical Benevolent College, Epsom, and we would earnestly solicit on his behalf the votes and interest of such of our readers as may be subscribers to the Institution. The case is strongly

recommended by Dr. G. H. Savage, of 3, Henrietta Street, W., and Dr. Herbert Manley, of West Bromwich; and proxies will be thankfully received by Mrs. Silverlock, 153, Portnall Road, St. Peter's Park, W.

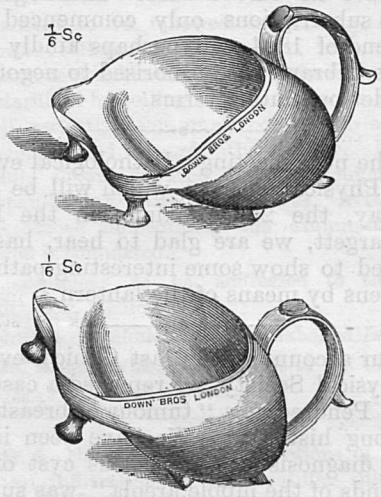
THE approach of the Cup Ties has begun to exercise the minds of the football enthusiasts as to the constitution and combination of the various Hospital teams, and as to the probable result of the competition. From a résumé of the First Fifteen's results, which will be found under "Sport," it appears that Guy's have hopes, and it is whispered that the struggle will be a keen one between ourselves, St. Thomas's, and St. Bartholomew's, who are reported to be a strong lot. We hope that a successful start may be made when Guy's meet St. Mary's on Tuesday next, and that our Association Eleven may prove equally successful when matched against Ewell in the first round of the Surrey Cup Ties to-day.

Notices.



MESSRS. REYNOLDS AND BRANSON'S BANDAGE SHOOT, of which we give two illustrations, is a handy invention which will be found of great use in every hospital and private surgery. The specimen which the makers have presented to the Hospital, and which has been hung on the wall of the women's surgery, is a neatly executed box in which a store of bandages of several sizes is kept. The bandages are readily taken from the bottom of the Shoot, and are thus kept perfectly clean and ready for immediate use. The claims made for the Shoot are principally that it takes up very little room, projecting from wall only 2¼ inches, that time is saved in searching for size of bandage, and that it can be bodily unhooked and carried to the scene of accident. The Bandage Shoot is made in two sizes, and the apparatus includes a strapping roll, a pair of scissors, simply contrived but effective tourniquet, and fitted to the back are two wooden splints suitable for arm or leg. The price of the whole apparatus is also very cheap; it may be purchased either empty or filled with white-wove absorbent bandages.

A NEW DRESSING TRAY.



This dressing tray, which has been designed by Nurse Manchester, of the Guy's Institution, is, for many purposes, an improvement on the ordinary kidney-shaped and three-cornered trays now in use in the hospitals.

It is made with a curved front, fitting almost any part of the body, and a raised back, which prevents the nurse from getting splashed, whilst the handle serves to keep the hands from coming in contact with foul discharges.

It holds three pints and a half of fluid, and for all large dressings where irrigation is required, especially colotomy or empyema, this will be found most useful.

The tray is also particularly convenient for the subsequent use of patients who have undergone the operation of colotomy. It is made by Down Bros., 5 and 7, St. Thomas's Street, London, S.E.

Appointments.

LEIGH, WILLIAM WATKIN, L.R.C.P. Edin., M.R.C.S. Eng., has been appointed Medical Officer for the Llanfabon District of the Merthyr Union.

POOLE, W., M.B., B.C. Cantab., has been appointed Medical Officer to the British Central African Administration at Zamba, in the Shire Highlands, south of Lake Nyassa.

TAYLOR, B. R. A., M.R.C.S., has been re-appointed Surgeon of the Kendal Provident Dispensary.

TUBBY, ALFRED HERBERT, M.S. Lond., F.R.C.S. Eng., has been appointed Assistant Surgeon to the Westminster Hospital.

TURNER, GEORGE, M.B. Cantab., D.P.H., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Hoddesdon Urban District Council.

Reviews.

The Prevention of Smallpox, with special reference to the Origin and Development of the Stamping-out System. By Edgar M. Crookshank, M.B., J.P. (London, H. K. Lewis). Price 1s.

The author gives a brief but most interesting account of the Plague as it occurred in London up to the time of the "Great Fire"; next follows a short description of the introduction and spread of smallpox in England. In reviewing this subject, the writer points out the wisdom and excellence of the "Rules of Prevention" which were suggested by Haygarth in 1778, and states further that, had they only been adopted, the spread of the disease might have been lessened or even entirely prevented. Had the author confined himself to pointing out the importance of notification, isolation and disinfection, in preventing the spread of the disease, all doctors would have agreed with him, but he goes out of his way to abuse vaccination, and in this we think his statements are open to the grave charge of unfairness. As an instance of the prejudiced nature of his remarks upon this subject, we may quote the following passage, which occurs on page twenty-nine: "We have been taught in the past to speak of "Wicked Leicester," and to listen to the most dismal prophecies, repeated year after year, of the appalling disaster which was bound to occur if once the disease was imported there. Similar statements appear even now in our medical papers, but they are mostly supplied by public vaccinators or other interested and prejudiced persons."

An Introductory Lecture on the Public, the Profession, and Medical Charities. By Robert Boxall, M.D. (London, H. K. Lewis). Price 1s.

The most valuable portion of Dr. Boxall's paper is to be seen at the end of it, where we find carefully worked out tables, which give the statistics of the increase in recent years in the number of persons seeking relief from hospitals. The figures are somewhat startling, for the author shows, that whilst the numbers attending general hospitals have not increased to a much greater degree than the increase of population warrants, the case is altogether different with regard to the hospitals and dispensaries which have no medical schools attached to them; for in these the increase has been so great as to make it evident that very large numbers of persons are now treated free of charge who a few years ago must have been attended by their own doctors, and who, therefore, presumably were capable of paying for medical attendance. Either this means that there is much more poverty now than there used to be, or that some of the profession are being defrauded out of their just due. Whichever explanation is accepted, there is evidently cause for grave reflection and need for anxious consideration. As to the remedy for so serious a condition of affairs, the author is silent.

Preservation of Health in India. By Sir Joseph Fayrer, K.C.S.I., M.D., F.R.S. (London, Macmillan & Co.). Price 1s.

This little book contains short, concise and popular directions for the maintenance of health in India, suggested by the author's wide experience and special knowledge of the subject. They will be invaluable to those who propose spending some years of their lives in that country. However, it is not only to Anglo-Indians that we would recommend this little volume, but also to those who have to treat patients who have lived in the tropics.

The Aseptic Treatment of Wounds. By Dr. C. Schimmelbusch. Translated from the Second German edition by Alfred Theodore Rake, M.B., B.S., F.R.C.S. (London, H. K. Lewis). Price 5s.

Mr. Rake is to be warmly congratulated upon his translation of Dr. Schimmelbusch's well-known book. The advances made in the domain of aseptic surgery during the last few years have been so great that a distinct need has been felt for a clear and concise account of the subject, and this want will be well met by the publication of the volume before us. No translation from the German can ever read so smoothly as an original production, but Mr. Rake has been singularly successful in minimising the inherent uncouthness of German phrases put into English words. Here and there sentences occur which are perhaps a little wanting in clearness, but they are rare, and, so far as we have seen, unimportant. The book can be warmly recommended to all who either practice or profess scientific surgery.

The Theory and Practice of Medicine. By Frederick T. Roberts, M.D., B.Sc., F.R.C.P. Ninth edition (London, H. K. Lewis). Price £1 1s.

The fact that Dr. Roberts' well-known book has reached a ninth edition shows that it still retains its popularity as a text-book of medicine. As a tabular statement of diseases, and of their supposed causes, course and treatment, this volume, like its predecessors, is excellent, but as a treatise on medicine we cannot but feel that it is sadly wanting in perspective, and that by giving as it were a view of medicine on the flat it rather loses sight of the depth and far-reaching character of the healing art. In certain portions of the book the accounts given are not quite up to date, and some new methods of treatment which have recently come into vogue are not mentioned at all. Still, on the whole, most of the important advances that have been made within the last few years are included in this edition. Some of the sections have been considerably added to, whilst others have been practically re-written. The subject of bacteriology in especial has received much more attention than heretofore.

Foods.

A Paper read before the Pupils' Physical Society on January 19th, 1895, by Mr. E. IVENS SPRIGGS.

MR. PRESIDENT AND GENTLEMEN,—Since organic forms appeared upon the face of the earth, nutrition and generation have been the factors of existence. The immediate problem is nutrition; the ultimate one, generation.

Organic existence, as compared with inorganic, is characterized by its relative instability; it is only relative, for minerals on the surface are always becoming oxidized. But whereas a piece of stone in the lapse of time passes from proto- to peroxide passively, and is changed, the life of the protozoon, though dependent upon its relation to the matter of which it is composed, is independent of the actual particles which make up that matter; from time to time the oxidized portions are thrown off, their potential energy has been used and they are no longer needed. But the individual remains though the substance changes, and it is this automatic power of prolonging existence which characterizes the living being.

Morphologically, the living element is the cell; the ultimate element is really the albuminous molecule. Weissmann has called this the "biophore," and describes it as consisting of several chemical molecules. Since it is always breaking down, a constant supply of new material is essential for the continuance of vital activity in any form. Protoplasm "decomposes but to recompose." The necessity of food is the first fact of life.

Hence, the animal or the plant does not carry within itself all the essentials of continued existence; it is endowed with a constitution and a form which are probably suitable to its surroundings at birth; but unless it can conform to the external conditions which are always changing, its life is short and fruitless. The power of adaptation is the priceless inheritance of every organism, which enables it to fall in with those circumstances which it cannot control. If adverse conditions prevail, the individual will succumb to or surmount them according as this power is great or small.

The chief of these external conditions are climate, food-supply and protection from living foes. Sometimes one preponderates, sometimes another. In the Arctic regions, as Darwin points out for an example, the chief battle is with the elements.

It is evident that the operations and results of all these factors are closely interwoven. Climate, for instance, favours or checks the life of a species, either directly by extremes of temperature, or lack or excess of moisture, or indirectly by reducing food-supply, or aiding the propagation of a hostile species. It will be well, then, to turn for a moment to climate and protection from living foes before considering food, with which we are especially concerned this evening.

Primitive organisms were relieved of the necessity of adaptation to unequal climatic conditions. For long periods of time an equable temperature prevailed over the whole of the earth, and a luxuriant vegetation, now only found in the warmest regions, flourished in all. This is shown by the abundant fossils of tropical plants of the primary and secondary periods found in the arctic, as well as in the temperate and torrid zones. At such a time the only problems were food and self-defence; now there is this third inimical element in addition. In the tertiary period, climatic conditions gradually approximated to our own; this was succeeded by a profound change, as if Nature repented herself of her former clemency. The ice age has left a far-reaching impression upon the history of organic life on the earth. Creeping down upon the hemispheres from the poles, the fall of temperature produced a scantiness of food which drove all animals who could travel towards the equator. Probably the struggle for existence has never been more keen than at this time; all species crowded to the tropics and there fought for the necessaries of life. The immigrants were not confined to animals possessed of adequate means of locomotion, for these carried with them the seeds and germs of many varieties of animal and vegetable life, whose parent forms, unable to escape, were slain by the ruthless and frigid invader. A little reflection, however, upon the gradual nature of such a phenomenon as the advance and recession of the ice frontier, occupying immense lapses of time, suggests that the crowding and the struggle were probably far less vivid than they have sometimes been painted.

The immediate effects of climatic variations upon food-supply are very evident, and of the greatest importance to man as to all other organisms. A wet summer in this country is good for grass and bad for wheat. The effect on the latter is indirect as well as direct, because the moisture favours hostile organisms, such as mildew. Turning to the animal kingdom, plentiful grass furnishes the ox with an abundant supply of food, and man benefits. A failure of the local wheat crop, on the other hand, is an adverse circumstance for the human beings concerned. This is a very simple example of the method of illustrating biological phenomena from observations on domestic animals and plants, which, in the hands of Charles Darwin, yielded results of such great value.

Besides the struggle with the elements, each individual animal or plant has to enter into competition with a multitude of neighbours; with some the strife is an open one, amounting to war; with others, a none the less keen, though more hidden, conflict is always going on, for food, for place, or for progeny. Of these, the first is generally most important. Position is of evident value for a plant in order that it may obtain light and breathing space; both of these have reference to its nutrition, but light also serves to attract insects, so necessary in many cases for the propagation of the species.

A well-known experiment of Darwin's will give some idea of the numbers which fall in the fight. A small area of ground, a square yard or so, was cleared of plants, and the native weeds allowed to grow in it.

After a time, 357 seedlings were counted: of these, 295 disappeared before maturity was reached. Another case is that of preserved game, among which such ravages are wrought by ground vermin. It is stated that unless the vermin were kept under by artificial means, partridges and pheasants would not increase in number, even though none were shot for many years.

Every organism, however, is not hostile to every other. On the contrary, since the hunter is always liable to become a prey, it often happens that one animal befriends another animal or plant. The well-known case of the cats and clover, also given by Darwin, exemplifies this. Red clover is fertilised by the bumble-bee, who is himself a favourite delicacy of the field-mouse, while the field-mouse is much sought after by the domestic cat. Hence the life of our feline friend is of more value to agriculture and to the world than many people suppose. No justification, however, is offered for the existence of the city variety. Hæckel quotes this case, and adds that clover is a great factor in the feeding of good beef, and that upon good beef the excellence of the English national physique depends; and thus cats—and the old-maids who keep them—by a simple chain of events find themselves controlling the world's politics and ruling the waves.

A moment's thought shows the marvellous complexity of the relations which living beings bear to each other, and how intimately their destinies are interwoven. We are only able to isolate and consider a few of the agencies, but these are sufficient to point out to us the intricacy of the network which we cannot unravel. That climate and protection from living foes, which I have just briefly touched upon, have been the chief factors in the development of species, is well illustrated by some of the parasites who have placed themselves in positions where these conditions are practically absent. Memberless, mindless, and almost shapeless, these abortions complete their gluttonous cycle, reaping the retribution which Nature visits upon those who shirk her discipline and defy her great law of progress.

The problem of food-supply brings us at once to the relations between the two great natural kingdoms.

The energy for the processes of vegetable metabolism is derived by the agency of chlorophyll directly from the sun. Hence the plant converts inorganic substances, such as carbon dioxide, nitrates, sulphates, and water, into living protoplasm, materials of low into materials of high potential energy. The process is one of deoxidation; at the same time respiration—a process of oxidation—is carried on, but Mr. Blackman, of Oxford, has recently shown that mature leaves, fully illuminated, assimilate the whole of their respiratory carbon dioxide, and allow none to escape. The substances which serve as food for the plant are all soluble in water and diffusible, so that no special aperture is needed for the ingestion of food. The insectivorous plants form exceptions.

The animal, distinguished by its powers of resource in most matters, in this one of food has greater limitations than the plant, for it can only use material of high potential energy which has been previously manufactured in the laboratories of the vegetable kingdom. Albuminous foods are essential, and the process results in oxidation and a loss of kinetic energy, manifested as heat and work. Carbohydrates and fats can be made use of for a supply of carbon, but generally speaking they are not essential. Since these materials are insoluble in water and indiffusible, an ingestion aperture, or mouth, is characteristic of animals.

What is the lowest type of organism in the evolutionary scale, and what is its food? The monera have been put forward by Hæckel as the probable progenitors of organic life on the earth. They were distinguished from amœbæ by the absence of a nucleus. Since this, however, their identity has daily become more doubtful, as every new research renders it probable that the nucleus is present, although the known methods of staining have not always been able to demonstrate it. Or at the time of examination the organism may be in a condition in which the nucleus is scattered throughout the substance of the cell. They are now, therefore, generally classed with the amœbæ. Now, it has been shown that the amœba can only make use of food in the proteid form, that is, its nutrition is of the holozoic kind, like that of animals, and if this is the case it would appear that the monera cannot have been the first living element and the common ancestor of both animal and vegetable types; for when none but inorganic food existed, no holozoic creature could live. Let us look, then, at the lowest plants, the protophyta, which can assimilate nitrogen from ammonia and nitrates, and carbon from carbon dioxide, types of the holophytic method of nutrition. Here we find the presence of chlorophyll is an essential condition, and it is unlikely that the earliest organisms possessed chlorophyll. One finds such statements as that "some protozoa," which do not contain chlorophyll, "are probably able to feed like plants." This is not likely, and until we have evidence that the carbon of carbon dioxide can be built into protoplasm without the aid of the green pigment cells, in some instance which is accessible to our present means of experimental observation, it will be unwise to assume such a procedure.

There are, indeed, numerous small infusoria which are holophytic in their methods of nutrition, but these are of a distinctly higher type of differentiation. Some are of great interest, such as Eugenia, which, instead of hanging between the two kingdoms like the body of Sciron betwixt earth and sea, makes the best of both, for it is provided with chlorophyll and in the sunlight forms protoplasm from the elements, while a well-formed mouth and gullet into which particles are swept by vibrating cilia, enable it to avoid the necessity of even a temporary fast at night.

Professor Ray Lankester suggests that probably albuminoids existed before living protoplasm, as a previous stage of its elaboration, and that these bodies furnished food for the first organism, which were probably of a plasmodial type. Subsequently, the evolution of

chlorophyll having taken place, the animal type, plasmodium or amœba, presumably having exhausted the albuminoids, adopted the chlorophyll-bearing organisms for its food, hence the animal, though dependent on the plant, preceded it.

The arbitrary and conjectural nature of such a scheme is quite sufficient to show that the whole question must remain unanswered until experimental science has more accurately determined the classification and nutrition of the lowest known forms of life.

The food of the large class of fungi lies in complexity between the two groups we have just considered. Nitrogen can be obtained from inorganic sources, and in the case of some bacilli, from the free supply in the air. Carbon cannot be assimilated from carbon dioxide, as chlorophyll is absent; it is derived from various forms of organic matter—acetates and tartrates.

The mycetozoa, familiar as flowers of tan, have been called fungi; their habit of feeding on decaying animal matter has given rise to this error. There is an amœba-like stage in their life-history, and they are classed with the protozoa. They are regarded by some as one of the simplest organisms; unlike amœba, however, they possess the power of digesting boiled starch,

The phenomenon of symbiosis is an admirable illustration, upon a small scale, of the relations which we have just been considering, prevailing throughout the whole of nature, between the two kingdoms. Among the protozoa is a class known as the radiolaria; certain species, such as lithocircus, are always found associated with minute unicellular algæ, who live with the radiolarian inside its flinty skeleton. The little plants have been called "the yellow cells," and their specific name is trooxanthella. These are not parasites, for the partnership is an advantageous one for both organisms; the animal excretes carbon dioxide and nitrogenous matters which are essential to the plant, and receives in return, oxygen. Other minute algæ live in a similar way in sponges.

Every lichen is composed of two distinct organisms; this, however, is not an example of symbiosis, but of parasitism. The threads, or hyphæ, of which most of the substance is made up are fungi, and these feed upon the decomposing products of the green cells which form the plant proper.

The influence of food, both as to abundance and suitability, upon the origin of species, is a subject which would require a Darwin and a volume to do it justice, so great are its dimensions and its intricacy. It has, naturally, chiefly been treated in connection with the other conditions environing organisms; but many interesting observations have been made which bear specially upon our topic. Before, however, turning to experiment, let us look at history as geology shows it.

The seas and continents of the earth are far from constant, and are always changing: there have been continents where there are now seas, and all dry land shows traces of once having been under water. In some cases these transmutations have been followed out, and it is found that terrestial animals, whose earliest remains exist in some given locality, are usually living in places which are, or have been, connected with that locality by land. With plants the case is approximately the same, but not exactly, since there are many methods by which their seeds can be carried long distances over water. Now, the reason why these animals migrated from their homes was the insufficiency of food, and to this migration has been due the origin of many new species. In the process two factors were at work. In the first place, the emigrants came to new conditions and new kinds of food the further they went, and suiting themselves to these alterations in their environment, became changed by adaptation. Secondly, any new features, arising either by this means or by fortuitous variations, would be far more likely to be perpetuated than before, since no crossing was possible with the parent stock left behind. These wanderers were very often further protected from the opportunity of ever meeting their progenitors again by the subsidences of land I have referred to. Left on large or small islands, separated by water from the original mainland, they were placed in the most favourable position which can be conceived for differentiation from the ancestral type.

The experimental investigation of the whole subject has received a great filip of late years, on account of what I think we may now call the heresy of Weissmann. Unless the theories put forward by this distinguished biologist are incorrect, there is nothing to discuss under the heading of the influence of food on the origin of species. For if the properties of germ-plasm cannot be affected by anything that happens to it short of starvation or destruction by injury, the whole of the onus of the differentiation of types in development is thrown upon natural selection from fortuitous varieties; no change of diet or impoverished nutrition could cause "a re-shuffling of the molecules so as to effect a permanent phylogenetic change." The only result would be the negative one of the death of the weakly offspring. On the other hand, earlier authorities have perhaps been a little too ready to throw upon changes in nutrition phenomena for which they were otherwise unable to account.

In reviewing experiments upon the starvation of different species of animals and plants, it is impossible to separate the results of impaired nutrition, which give simply imperfect development from those which are manifested by adapted changes in the organism, giving rise to a new species. Distinct characteristics may be very much altered and even lost by an impoverished food-supply, which is not altered to a great enough extent to endanger life.

Chauveau found in experimenting with the bacillus anthracis, that although new and distinctive properties could not be conferred upon it, its pathogenetic influence could be so altered that even animals most easily affected were unhurt by its presence: they were, nevertheless, rendered immune from the virulence of the normal bacillus. Bacilli of various degrees of virulence can be

obtained by appropriate methods of semi-starvation. The bacillus of tubercle, again, is feeble when cultivated in broth made from the rat, the monkey, or the goose.

The Japanese have for centuries grown dwarf varieties of plants by a process of pruning the roots and keeping them in poor soil. It is necessary, however, that very gradual means should be employed, as in Rougon's experiments the plants became sterile. Mountain horses form a very distinct class which has been produced by a life of hard work and scanty food which is generally of a not very succulent nature. Much grass and similar vegetables, together with work in which a dead weight against the collar is advantageous, have produced the heavy and fleshy farm horse, so utterly different in form and size.

Variations in the constituents of an abundant food-supply have been shown to produce very marked changes.

The digestive system of animals, as we should expect, is very easily influenced. It would be treason not to mention John Hunter's sea-gull. This instructive animal was fed on corn instead of fish, and the wall of its stomach became hard and gizzard-like, similar to the type found in those species of birds whose habitual pabulum is grain. Dr. Edmonstone has shown that the change takes place yearly in a Shetland variety of gull, fish only being available for six months of the twelve. The accommodation of the alimentary canal in length to an animal on vegetable diet is a well-known phenomenon.

Much more subtle are the variations of colour which can be produced in plants, and have a far-reaching influence upon species. They are gradually, however, becoming nearer solution, now that so much work has been and is being done upon the chemical nature of pigments. The geranium batrachoides in a fertile soil is blue, but if it be raised in an unpropitious medium, the flowers become variegated or white. Carriére records a case in which, within a short time, some thousands of celery plants in a garden all became variegated. Linnæus and the older naturalists paid little attention to colour, thinking that it was so uncertain and transitory as to be not worthy of scientific investigation. This, however, is not the case. Inheritance always carries its influence as well as adaptation, of course, as is exemplified in the case of the pink roses which were budded on to a red rose tree; the alien twig, although receiving nourishment from the main trunk, still produced flowers. Professor Gautier has shown a chemical difference between the colours.

Some bird-fanciers believe that by feeding canaries upon mustard-seed, curcuma, saffron and alcohol in different proportions, the colour of the bird is affected; they also place yellow flowers and muslin round the cage. I do not think scientific investigation has yet confirmed the accuracy of this.

Farmers who breed sheep for show are well aware of the value of various kinds of food in making the wool fine and abundant, and statistics upon this point are very definite. Thus, ·870 parts by weight of wool were produced by sheep fed on abundance of hay; the result of feeding on good pasture was to produce ·958 parts, and with fattening food the yield was as much as 1.24 parts.

Enough has been said to show that changes in food can produce considerable variations in a species, even within the short periods with which we are able to deal. It will be readily seen that during the immense lapses of time which such agencies as these have had to work in, there has been ample opportunity for such varieties to still further diverge and form species; and in some cases accepted species have been shown to be mutually interchangeable by artificial methods, as when Fabrejou showed that from the same coriander seeds planted—some in fertile and some in barren soil—the two known species could be produced.

The most conclusive case I have come across, however, relates to an experiment by Brennan, in America, quoted by De Varigny. In 1872 a monocotyledonous plant, Tradescantia Virginia, was set out. The ovary is divided into three segments, that is, is trimerous, with three petals and three sepals, and six stamens. The plant was exceedingly well looked after as to soil and moisture and so on. In 1874 it left the trimerous type and developed an extra petal which was not stolen from the sepals, but was accompanied by a new sepal, a new carpel, and two new stamens. Two years later saw it pentamerous. In 1879 five segments had appeared on some of the blossoms, and in 1882 a dimerous form was shown. Heptamerous flowers were seen in 1886, and in the same year an ovary with eight segments was detected in one flower. The pentamerous type was much the most abundant. We have here before our eyes the evolution of a higher from a lower type, under the influence of advantageous nutritive conditions.

The persistence or extinction of a species obviously depends much more upon the external conditions, and upon its power of adaption to these, than upon the number of offspring produced. Some animals lay millions of eggs, and yet so numerous are the agencies directed against them and so small their chance of falling into an environment where food is sufficiently plentiful that the species is quite rare. This is the case with many moths. On the other hand, the stormy petrel is one of, if not the most, plentiful of sea-birds, and only lays one egg: an almost inaccessible position is chosen, however, as egg-hunters can testify.

But we look to the lower orders for great power of adaptation to the hardships of life. M. Rouyon found that aurelia could withstand a diminution in body weight, by starving, equal to three-quarters of the whole, and yet be in apparently good health and condition. Many organisms, such as the yeast plant, can prevent their species dying out in times of famine by becoming encysted. The cell divides into four, a hard wall surrounds it, and thus a spore is formed which needs no food, and can resist the weather, until, finding itself in more benign circumstances, it gives rise to the active plant again. Roliph attributed parthogenesis to better nourishment, and this is supported by the fact that some

parthogenetic ova when deprived of food, as, for instance, by the drying of the puddle in which they live, take on sexual characters, some becoming male, and others female

Sex in many animals and plants, if not in all, is very distinctly affected by food. In some dwarfing experiments upon the snail lymnœa, it was found that the snails produced were principally females, and also that in most cases their lives had undergone degeneration. Yung has found in frogs, that beef as a food raised the percentage of females from 54 to 78 per cent., while a fish diet produced 81 per cent., and, if fed on frog-flesh, there were only 8 males to every 92 females in the offspring. In an average spawn of tadpoles females are slightly in the majority. Prault has made similar observations on ferns. Spores planted in a soil poor in nitrogen develope into male prothallia, especially if there is much crowding, while, if nitrogen is plentiful, and there are but few competitors for it, most of the prothallia contain archegonia, the female elements.

Reference has been made to the formation of small and hardy dwarf species by administering food which was inferior in both quantity and quality. Such a treatment, of course, will first stunt the individual development and growth, and not until later have any marked effect upon the progeny. M. de Varigny, of Paris, has been able to keep tadpoles from sexual development, in fact, to keep them in the gill-bearing stage for two years, by withholding suitable food. All other conditions were perfectly favourable to development; the aquarium was kept warm with good water in which plants flourished, so that there was no fear of starvation. The individuals experimented upon were spawned in the spring of 1889, and to quote M. de Varigny's words, "In the case of my tadpoles, it seemed that the completion of development was due to my imprudently feeding them in the Spring of 1891, on the very substantial flesh of their congeners, and in the course of some three weeks at most the limbs were evolved, the long tail disappeared gradually, the colour and appearance of the skin underwent considerable changes, and my superannuated tadpoles became toads at last." Interesting as this experiment is, it is surpassed by those following it, which showed that similar results can be obtained with the newts and salamanders, but the tadpoles, if their development be sufficiently delayed, do become sexually mature, even though they may never get their lungs. These are excellent illustrations of the power of adaptation. The toad and the salamander require more expensive and less easily obtainable food than do their tadpoles, which represent their earlier and ancestral food; deprived of this food, they are unable to make that progress which, under kinder circumstances, should have followed. Determined not to give up, however, life is still preserved, and, living the lives of their remote progenitors over again, they are able in some cases to reproduce their species, just as the immigrant, removed from the luxurious and plentiful regimen of civilization, is still master of his fate, and settles down to such a diet as his ancestors lived on when they were in his position hundreds of years ago.

I have mentioned that partial starvation can produce sterility. Darwin has shown that a sudden change from a poor to a rich diet has the same effect as is the case with captive animals, although they may be placed under the best possible conditions and given plenty of exercise. Hæckel instances the bears and elephants in national collections, such as the Jardin des Plantes and our own Zoological Gardens, which very often fail to produce offspring. But bees, as is well known, feed the larvæ which are to become queens, or perfectly sexual females, on a rich diet; an inferior pabulum produces workers, "abortively sexual females." And it is generally true that the effect of more nutritious food upon a species is an increase in the power of reproduction. Darwin has pointed this out from observations upon quadrupeds and birds, which he found multiplied much more quickly in the tame than in the wild state. He observes that this is also true for barbarous, as compared with civilised races of men, and attributes it in both cases to the causes which I have mentioned, not forgetting, however, that the latter are more humane in their treatment of infants, and more protected from epidemics and the sanguinary raids of neighbouring foes. The potency of disease as a check upon population among savages is exceedingly great. Vaccination and other hygienic and prophylactic measures, practised on one of the tribes of British India caused their numbers to obviously increase by leaps and bounds, in a comparatively short period. And yet, though such treatment is far more general all over India than formerly, the population is kept down by the famines which periodically sweep over the peninsula.

It will be well here to make some limitations and define what is meant by more nutritious food, as regards the diet of man. The savage gets his meals when he can; he will gorge for weeks on flesh, and he will starve for months on uncooked, or badly cooked vegetables, and what little meat robbery or the chase may yield him. The English artizan feeds regularly on simple, wholesome, and plentiful food; there is no great variety, but the proportions are tolerably constant, and not dependent either upon the seasons or upon intertribal politics. The latter is well nourished, the former is not.

But how far can this parallel between animals and men be continued? Is there no limit to the numerical increase of man, because his food-supply will become more and more assured to him as his power over the conditions which surround him increases? Is it possible that the one result of the slow and painful evolution of his versatile genius, and of its application to such problems as the means of subsistence, the alleviation of disease, and the prolonging of all human life, be simply this—that each succeeding generation shall find subsistence more scarce, and competition for food more keen, until the crowds become multitudes, and the multitudes mobs, and each man, fighting with his fellow for food, shall return to the condition of the beast from which he arose? Of such magnitude are the questions which present themselves to our minds.

To this point, the relation between food and population' the consideration of our subject inevitably brings us.

The application of the principle of the struggle for existence to mankind, too blindly and without sufficient thought, has often caused as awful a prognosis of the future of man upon the earth as I have just outlined.

From the anthropoid apes downwards in the scale of life, the existence and increase of each species is limited by its power of obtaining food, of withstanding the changes of climate, of overcoming rivals, and so on. The same is true of man, with this addition, that he himself can exert an influence upon those conditions. Does he wish to use any particular animal for food?—he hunts it, but he also preserves it, and, instead of the aggregate food-supply diminishing, it increases. The astonishing fertility of many species is exemplified in the startling statements which are familar to you announcing the number of offspring which would result in a given time if life were assured to each individual: under such conditions one pair of herrings, or of salmon, would people the ocean at an almost incredible rate; and the same is true of mammals, and to the same extent, if only the time factor be a little lengthened. Now, man has the power of putting many species under conditions approximating to these, and practically of indefinitely increasing his food-supply. Another old adage must go, for man can both eat his cake and have it. As Henry George says, "With man the limit of subsistence is, within the final limits of earth, air, water, and sunshine, dependent upon man himself."

But the objection comes: If population is increasing, it logically follows that it must ultimately press against the limits of food, and therefore the last argument only pushes the difficulty further away and does not remove it. In considering this, the question must be asked—Is population increasing? Investigations have been made, and, although estimates are conjectural, there is abundant evidence that the growth is nothing like so great as is often supposed. Malthus's idea of population increasing in a geometrical ratio, while subsistence only increases in an arithmetical, is a formula which has long been dismissed even by those who have been amongst the most staunch of his disciples. The greatest use which his Essay on Population has served was the stimulus which it afforded to the mind of Charles Darwin. It has been pointed out that in China the descendants of Confucius are all known and are endowed with privileges which place their lives under excellent conditions as regards the struggle for existence. According to Malthus, there should have been, 2,150 years after the death of Confucius, a number of them, to express which requires twenty-seven figures. There were actually 22,000. This is a large number, but it represents the offspring of many other people, some of whom were contemporary with Confucius, and with whose descendants his children have intermarried, so that fresh blood representing other ancestors has constantly been introduced. Instances of famous families whose line of succession has failed are numerous throughout history.

But, leaving individuals, let us look at nations; the Anglo-Saxon race is rapidly extending its borders, but at whose expense? The countries we colonise are not unoccupied, but in every case some other race is sacrificed. New conditions, new foods, new arts tax the power of adaptation of the conquered to too great an extent, and though conquest does not always mean war and massacre, none the less surely are the aboriginal inhabitants of our colonies becoming extinct. And their number was by no means insignificant. Africa has certainly been occupied by nations whose numbers were immense before the slave trade. The north coast, too, in Hannibal's time, had a population exceeding its present one, and, indeed, the same applies to all the classic regions. North America and South show remains of a civilization which preceded the barbaric state in which Columbus and Cortez found them, and this could only have been reached and supported by nations of considerable magnitude. India and China also have probably contained larger populations than they do now. With respect to Persia and the surrounding regions, the fact is undoubted. Add to this that enormous ages have lapsed since man is supposed to have first existed on the globe, and it will be seen that neither history nor probability support the theory that the aggregate number of men on the face of the earth is increasing at any considerable rate, and the possibility of crowding is relegated to such a remote period, that it would be folly to discuss it, even if our knowledge of the human race as a whole furnished us with premises much more distinct than we have at present.

There still remains one question to be dealt with. Since the dominant races of mankind are gaining a control over the natural sources of food, which is likely to increase in the future, and since the security is more assured as each century rolls by, is there not likely to be a great acceleration of the rate at which the race multiplies? Darwin's experiments on the domestication of animals, to which I have referred, point to this, as do his comparisons between barbarous and civilised men. But in this case we must compare, not barbarous with civilised, but civilised with more civilised, and it is in this case that the saying is true, "A rich man for luck, and a poor man for children," for abundant facts can be adduced to show that as the development of the intellect and the comforts of life increase, so the dangers of crowding and the evils of too keen a competition diminish.

To any who would point at the poverty of the day, it should be answered that there is food and enough for all, but that economic and political conditions have not yet reached a sufficient stage of perfection for its adequate distribution.

But this leads us, gentlemen, beyond the usually accepted bounds of biology, from which I am afraid you will say I have already strayed too far.

If such a view of the future of man's history upon the earth as I have taken appears to you to be too optimistic, I would remind you that no true evolutionist can be

anything but optimistic. You are exceedingly jealous of man's development from lower forms, but remember that his progress is not towards, but away from those forms. The animal lies behind him, but before him stands the perfect man.

Sport.

Association Football.

GUY'S HOSPITAL v. REIGATE.

Played at Reigate on January 19th, and resulting in a win for Guy's by four goals to one, after an uninteresting and scrambling game. Reigate won the toss, and the Hospital kicked off with the advantage of the hill. Play ruled pretty even for the first ten minutes, but the homesters managed to score a lucky goal from a corner kick; after this Guy's had considerably the best of the play, and Fitz-Hugh, who was standing palpably off-side, was fortunate enough to receive the ball from a mis-kick off one of the opposing backs, raced down the field, and equalised with a very feeble shot. A lot of give-and-take play followed, but at length Humphry, taking a pass from Stamford, wound up a magnificent single-handed run by placing the Hospital a goal ahead. Just before the whistle sounded for half-time, Palmer increased our lead with a low screw shot.

The first quarter of an hour of the second portion was all in favour of Reigate, but the defence of Barker and Carter was simply perfect. After this, Guy's gradually wore the homesters down, and towards the end Fitz-Hugh, receiving a pass from Palmer about mid-field, out-paced the opposing backs, and scored our last goal with an oblique shot.

Carter, Fitz-Hugh and Mandy were the pick of the team, and it was chiefly owing to their strenuous efforts we returned home victorious.

As the Surrey Cup tie is played to-day (January 26th), a few remarks may not be out of place. The forwards must show more combination than they did in this match, and remember to pass low and sharp. The half-backs do not keep close enough to their forwards, and as a consequence many good openings are lost. They must also feed the front rank better, and kick low and straight.

Rugby Football.

GUY'S 1ST XV.

RECORD TO SATURDAY, JANUARY 19TH, 1895.

Matches played, 13. Won, 6; lost, 6; drawn, 1.

Scored for: 2 goals (1 from a mark) and 11 tries = 42 points.

Against: 8 goals (1 dropped) and 9 tries = 66 points.

Tries.—By Bell, 5; Rae, 3; E. Morgan, 2; Wetherell and Mathias, one each.

Goals.—By Hancock and Dudgeon.

Thirty-one members have been tried in the 1st XV.—14 backs and 17 forwards:—

2	members	have played in	13 matches.
1	"	"	12 "
2	"	"	11 "
1	"	"	10 "
3	"	"	9 "
2	"	"	8 "
1	"	"	7 "
4	"	"	6 "
3	"	"	5 "
5	"	"	4 "
1	"	"	3 "
1	"	"	2 "
5	"	"	1 "

After reading the above, I do not think anybody can accuse the Committee of not having tried enough men.

Our victories have been gained over Rosslyn Park, Wickham Park, East Sheen (2), Catford Bridge, and Lennox. Our losses by Cambridge, Leicester, Leeds, Coventry, Bristol, and Northampton; and the drawn game with Old Merchant Taylors.

Five of our six losses have been in matches played away from London, and we sustained defeat when Leeds came to Honor Oak. Up to the present, therefore, we have not been beaten by a London club, although it must be remembered we have only played two of these in the first class, viz., Rosslyn Park and Old Merchant Taylors.

The team has not done too well so far, but this may be partly explained by accidents. On paper the Cup team seems to be rather a good one, as 10 members out of the 15 have played for their respective counties. This ought to be good enough for most teams, and if really fit, and we meet with fair luck, we ought to go very near that Cup.

H. W. DUDGEON, Hon. Sec.

GUY'S 2ND XV. v. LONDON AND WESTMINSTER BANK.

This match was played on our ground, on Saturday, January 19th, and resulted in a win for the Hospital by a goal (5 points) to nil. The ground was very heavy and the game of a scrambling nature. The try was obtained by Carter. The Bank, thinking the whistle had sounded, allowed Guy's forwards to dribble the ball over the line. Cleveland took the kick, and was successful.

Carter and Edwards were the pick of a good pack of forwards. Biggs, Bryant and Clarke showed up best of the back division.

Birth.

KIRBY.—On December 25th, at Hull, the wife of W. L. Kirby, of a son.

Death.

SCHMIDT.—On January 5th, at 150, Bethnal Green Road, Alfred Edwin Schmidt, L.R.C.P. Eng., L.R.C.S. Eng., L.S.A., aged 56.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor*, Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette,

FEBRUARY 9, 1895.

Malignant Disease of the Liver.

CLINICAL LECTURE ON TWO CASES BY DR. W. HALE WHITE.

THE first patient, whom you see, is 41. He has never been abroad; he is said to have had syphilis, but this is doubtful. For the last fifteen years he has been a barman. In May, 1894, his urine became dark, his skin yellow, he had xanthopsy, and his motions were clay-coloured. He came into the Hospital under Dr. Taylor; then his liver was uniformly enlarged, and extended within two inches of the umbilicus; it was not tender; the gall-bladder could be felt; he was jaundiced, there was bile in the urine, and the motions were clay-coloured. He finally left the Hospital on October 26th, his condition being unchanged.

January 1st, 1895. He was very weak, he noticed that his feet and abdomen began to swell, so he came in on January 21st. The jaundice has varied in depth, but has been constant, and the motions have generally been clay-coloured.

On admission.—He appears wasted; he is deeply jaundiced, of a dark greenish-yellow tint; there are many scratch marks showing the itching due to the jaundice. He has some internal piles; there is no evidence of syphilis; the abdomen is uniformly distended, and gives the ordinary signs of ascitic fluid. Measurement shows that the vertical extent of hepatic dulness has increased half-an-inch since he was in before. The edge of the liver can easily be felt, a little above the umbilicus, it is uniform, and not excessively hard nor particularly soft. The notch can be readily distinguished; in the position of the gall-bladder, and attached to the liver is a soft globular swelling, the size of a tangerine orange, apparently containing fluid, which we take to be the gall-bladder. There are two very tender points on the surface of the liver, one over the left lobe, the other below the ribs in the mid-axillary line. The rectum is normal; the motions vary, but are often clay-coloured, and the bowels are open several times a day. There are no venous stigmata on the cheeks; there has been no vomiting nor hæmatemesis; there is no evidence that the spleen is enlarged; the urine contains bile and urates. Excepting that the apex of the heart is a little displaced to the left, there is nothing noteworthy about the chest.

The second patient, a man, who died yesterday, aged 43, was admitted January 26th, 1895, for jaundice, wasting, and abdominal pain. His father died of a tumour of the testicle. He has never been out of England, and there is no evidence that he has ever had syphilis. On the whole he has had excellent health until the present illness, but he has been liable to slight attacks of indigestion lasting a day or so, and accompanied by some pain but no sickness, and clearly, from his account, they have not seemed to him to be of much importance.

Six weeks ago he began to get weak, and for three weeks this weakness increased; he then found that his appetite failed and that his urine was dark. He had to give up work, and he began to feel a cutting pain in the hepatic region increased by coughing. A fortnight ago he was so ill that he went into King's College Hospital, but he was only there nine days. Two or three days ago he began to get yellow, and his urine became very dark.

On admission.—He is much wasted, considerably jaundiced, and looks very ill. His weight is nine stone four pounds; in health it was twelve stone. The epigastric angle is wider than normal. The liver is obviously very much enlarged. Its lower edge is hard and reaches very nearly to the umbilicus, just above which is the hepatic notch. The upper limit of hepatic dulness is normal in the nipple line, but does not fall as it should, for it reaches the upper border of the sixth rib in the mid-axillary line, from which it falls to its normal position at the base of the right chest. On the surface of the liver two rounded prominences can be felt, one about two inches above the umbilicus, the other just below the eighth and ninth costal cartilages. A rub can be felt and heard over the surface of the liver when the patient breathes. The spleen cannot be detected. There are a few râles at the right base; the apex of the heart is displaced up a little. He is occasionally sick; the vomit contains no blood, but hydrochloric acid is present. The rectum appears normal. The motions are clay-coloured. The urine contains bile and a very large amount of urates. On January 28th, he showed signs of bile-poisoning or cholemia, the chief symptoms of which were unconsciousness and drowsiness, with at times slight delirium. The liver increased in size, so that before he died on February 1st it was below the umbilicus. I particularly want you to notice the increase of normal dulness upwards in the mid-axillary line, for, as it was dome-shaped, we concluded that it was not due to fluid within the chest, as in that case it would have been a horizontal line, therefore it must have been due to something in the liver, or between it and the diaphragm, and, as the liver was obviously diseased, we concluded that the former supposition was correct.

It is obvious that there are many points of view from which we might consider these two cases, but in the short time of an hour we can only take one. I propose that we should, in each, start with the undoubted fact that the liver is enlarged. Whenever you are examining the liver, you should always make a habit of remembering that it may appear enlarged when it is not; for instance, it may be pushed down by fluid in the chest or by tight-lacing, and in children it is, in health, proportionately larger than in adults; or, again, other abdominal tumours, such as a thickened omentum, may, by their proximity to the liver, give an impression that it is enlarged. It also may appear much smaller than it really is, for the enlargement may be hidden by an accumulation of gas or fluid in the abdomen, or by emphysema in the chest; but after bearing all these fallacies in mind we came to the conclusion that the organ was in both our patients undoubtedly enlarged, the chief reasons being that the enlargement and the dulness were such as we should naturally expect with a large liver; the lower edge felt like and occupied the position of the edge of an enlarged liver; it moved freely with respiration; the patients had other signs of hepatic disease, but none of any of the fallacies we have mentioned. What, then, are the causes of enlargement of the liver? They are:—

(1.) *Passive venous congestion* generally from heart disease or bronchitis. I have often demonstrated this to you, and have shown you that the liver is uniformly enlarged and frequently very tender and painful, the pain being much relieved by leeches and a dose of calomel. However, in these cases there was no cause for venous congestion, and the jaundice was too deep.

(2.) *Passive portal congestion.*—This gives rise to only slight enlargement of the liver, but it may occur if a habitual discharge of blood from piles is cured by operation, or it may be seen in those who suffer from chronic constipation.

(3.) *Active congestion.*—This is seen chiefly in India, where the combination of high temperature with irritating articles of food gives rise to enlargement and tenderness of the liver. Do let me beg of you never to say for a diagnosis that a patient has congestion of his liver. It is a popular phrase, and even if you believe it to be present—which it often is not when the patient declares it is—you sail very near to the class of ignorant quacks if you do not try to find out the cause of it, and from that you should make your diagnosis.

(4.) *Malaria;* and

(5.) *Yellow fever.*—

These causes of enlargement obviously do not apply to our present patients.

(6.) *Leuchæmia;*
(7.) *Hodgkin's disease;*
(8.) *Pernicious anæmia;* and
(9.) *Diabetes.*—

There was no evidence of any of these, in all of which the enlargement of the liver, if it occurs, is uniform, painless, and unaccompanied by jaundice.

(10). *Fatty liver.*—In our cases the enlargement was very extreme for a simple fatty liver. Moreover, a fatty liver feels soft, is painless, smooth, uniform, does not evert the ribs, and does not cause jaundice or ascites.

(11.) *Hydatid.*—In this disease of the liver there are localized tumours of it, and therefore the localized enlargement upwards and the lumps on the anterior surface in the second case might have been due to hydatids, but there was no thrill, the patient was far too ill, the course of the disease was too rapid; also jaundice and clay-coloured stools are usually absent in hydatid, for it is rare to get a hydatid tumour pressing on the bile-duct, and therefore we decided against hydatid. In the first case, the enlargement was too uniform, and, again, the jaundice and clay-coloured stools showing pressure on the bile-duct helped us to exclude hydatid.

(12.) *Tropical abscess;*
(13.) *The single large abscess found in those who have never been abroad;*
(14.) *Suppurating hydatid;*
(15.) *Actinomycosis;* and
(16.) *Tubercular abscess.*—

The long duration of the first case, and in both the absence of pyrexia, rigors, and other general and local signs of suppuration, enabled us to exclude these conditions. You will remember that last year, in a clinical lecture, I pointed out that sometimes the solitary abscess which occurs in those who have never been abroad is associated with ulcerative colitis. Actinomycosis is very rare. You will find a case recorded by Dr. Taylor in the Guy's Hospital Reports. Tubercular abscess is even rarer, and most supposed cases of it are really examples of actinomycosis; still, an undoubted example has been recorded by Mr. Mayo Robson. Remember that pyæmic abscesses of the liver are never large enough to give rise to tumours that can be detected during life.

(17.) *Perihepatitis.*—This only causes an enlargement of the liver sufficient to be detected during life when the hepatic capsule is very much thickened. It then forms an opaque covering for the liver, as you see in this specimen, and the lower edge of the liver gets turned under on itself; consequently, the edge you feel is thick and rounded. But the liver in neither of our cases has such an edge, and in both it is far too big for the increase in size to be due solely to the thickening of the capsule.

(18.) *Obstruction of the common or of the hepatic duct.*—When this occurs, the bile gets dammed back in the liver, and so may cause the liver to be a little enlarged, but in both our patients the enlargement is far too great for this to be the sole cause.

(19.) *Lardaceous disease.* — Uncomplicated lardaceous disease of the liver causes the organ to be uniformly large—often very large, with a hard edge. There is no pain, tenderness, nor jaundice, and if the enlargement is very great there should also be enlargement of the spleen, and albuminuria from lardaceous disease of the spleen and kidneys, also a history of suppuration or syphilis is usually obtainable. You will at once see that our cases cannot be examples of a simple lardaceous liver.

(20). *Hypertrophic cirrhosis.*—In this disease the enlargement is uniform, the liver feels hard and sometimes smooth, but often distinctly uneven; it is rarely tender. We did not think our second patient had cirrhosis, because the enlargement was not uniform, he had considerable pain, the liver enlarged rapidly under observation, the jaundice was deep, and there is no history of alcohol. In the first case the question is far from easy, the fact that the patient has been a barman is a very strong point in favour of the view that he has cirrhosis, and, also, I have repeatedly urged to you at the bedside of other cases that in cirrhosis ascites appears very rapidly and often quite unexpectedly. Time will help us much in our present patient, he has now had his ascites for a month. Out of twenty-two cases of cirrhosis with ascites, five were dead within a month from the first day on which the patient noticed the abdomen to be swelling, and the average duration of life was only two months. The œdema of the feet is also a point in favour of cirrhosis, and I have often given you reasons for believing that the ascites and swelling of the feet are not mere pressure effects. A patient with marked cirrhosis of his liver, may present no symptoms at all of

it, for it is often found accidentally in the post-mortem room, but all patients who have a cirrhosed liver are liable to the more or less sudden supervention of symptoms which rapidly increase in severity and usually soon end in death. The chief are ascites, swelling of the feet, and a general feeling of illness and drowsiness. Now, while it is true that, as our first case conforms to much of this description, if we diagnose cirrhosis we shall have an explanation of many of his symptoms, nevertheless the following points must be urged against such a diagnosis, namely, he has clay-coloured stools, his jaundice is deep and is getting greenish, and his gall-bladder is dilated, all of which mean that there is some actual obstruction to the common duct which never occurs in uncomplicated cirrhosis. Further, death usually takes place in cirrhosis soon after the supervention of jaundice, but this patient has had it for months. Also, it is especially those cases in which the liver is big that death takes place soon after the patient complains, and before ascites developes. Then, again, the spleen is enlarged in half the cases of cirrhosis, but it has always appeared normal in this man, and it is just in these cases in which the liver is big that it is most often enlarged. Lastly, the diagnosis of cirrhosis does not explain the tender spots on the liver, there are no other signs of cirrhosis, *e.g.*, gastric, the look of the face, etc. I should, however, add that it is with the large cirrhotic liver that jaundice is most often seen, but it bears on this case to state that I find, among 68 cases of hypertrophic cirrhosis of the liver, collected by Dr. J. A. P. Price, in the Guy's Hospital Reports, jaundice and ascites together only occurred 19 times, and in 29 neither symptoms were present.

(21). *Congenital syphilis.*—We may quickly dismiss congenital syphilis of the liver. It exists in two forms; the commonest is only met with in quite young children, the organ is slightly enlarged, hard, and of a grey colour from excessive growth of new interstitial tissue, especially round the portal vein, which does not go on to the formation of contracting fibrous tissue, and therefore the liver is not like a cirrhotic liver. The second form is especially interesting to us, for we had a boy in Stephen who showed it admirably. The organ is enlarged, hard from the formation of new fibrous tissue, and irregular from the presence of many gummata. The boy was six years old, his liver reached nearly to the umbilicus, but I never read or heard of this condition existing after the age of sixteen.

(22). *Acquired syphilis.*—When the liver is affected, gummata ranging from a few up to fifty, and differing in size from a pea to a tangerine orange, are deposited in it, and broad fibrous bands, it may be a quarter of an inch wide, appear running through the liver in various directions. As the gummata are absorbed, or the bands contract, we get a number of depressions on the surface of the liver, with fibrous bands radiating from each depression. These scar-like depressions are absolutely diagnostic of syphilis. Nearly always a syphilitic liver is more or less lardaceous, so that you can easily understand that the liver is hard, irregular and enlarged. But we never for a moment thought our second case was syphilitic disease of the liver, for he was dying, the course of his disease had been very rapid, and he was jaundiced. In the first patient there may be some doubt, but, on the whole, I do not think his is a syphilitic liver, because, for its size, it is not irregular enough, he is jaundiced, has ascites, and passes clay-coloured stools, which would mean that a gumma or a lardaceous gland is pressing on his bile-duct and portal vein, but both these are so excessively rare as to be only pathological curiosities. I show you a specimen of a gumma pressing on the portal vein. Then, again, although you may have pain in a syphilitic liver from coincident perihepatitis you rarely get tenderness; and, lastly, the man has no signs of syphilis. Still, he is having Iodide of Potassium on the chance that we are wrong in regarding the liver as non-syphilitic. Up to the present time he has not improved under it.

(23.) *Malignant Disease.*—In our second case, the wasting, the fact that the man was dying rapidly, that his jaundice was quickly becoming very dark, that the urine contained much bile, that the motions were clay-coloured, that the liver was very large, irregular and hard, with palpable masses on it, that it increased rapidly in size—all pointed so certainly to malignant disease of the liver that we diagnosed it feeling sure that we were right. Further, we were able to say for certain that he had secondary enlargement of the glands in the portal fissure, and that they were pressing on the hepatic or common duct, for deep greenish jaundice, much bile in the urine and clay stools, always mean obstruction to the flow of bile after it has left the liver.

Whenever you have made out that your patient has malignant disease of the liver, you must always begin to search for the primary

seat in some other organ, for the liver is so rarely affected with primary malignant disease that this diagnosis can never be made with any probability of success.

The commonest seat of the primary disease is the stomach, but in our patient there was no evidence that this organ was affected, and the presence of free hydrochloric acid in the vomit was against this view. The next most likely primary seat is the gall-bladder, the growth being set up by the irritation of a gall-stone, but we could get no history of this. The rectum was healthy, and no primary seat could be found anywhere. When you have no clue as to the primary seat, it is very probable that it is in the head of the pancreas, and so we suggested that our patient had primary disease of the head of the pancreas, with secondary growths in the liver. If you look at these organs removed from the patient yesterday, you will see that this diagnosis is correct Here is a large mass of primary carcinoma of the head of the pancreas; here are several enlarged glands in the transverse fissure of the liver which press on the hepatic duct, and so have caused the jaundice. The fluid found in the gall-bladder was colourless because no bile could reach that structure. The liver, you see, is enormously enlarged, it weighs nineteen pounds and it is crowded with masses of secondary growths. You see the especially large lumps on its anterior surface which we felt during life. You see a large mass on the upper surface of the right lobe which caused the dulness to be higher in the axilla than normal. You notice, too, that at some spots, where a growth on the surface of the liver was in contact with the abdominal wall, nodules of carcinoma developed in the peritoneum from contact, and you can easily see how the growths rubbing together during respiration produced a rub. Some growths are umbilicated, which is a common occurrence in hepatic cancer, and the depression may even be detected during life. Lastly, you notice a quantity of hæmorrhage in the hepatic substance which partly explains the rapid increase in size of the liver which was observed during the few days the patient was alive.

With regard to primary carcinoma or sarcoma of the liver, it occurs once in about every thirty cases of malignant disease of that organ, but, as in the twenty-nine cases of secondary hepatic growth it will be possible to detect the primary seat during life in a certain number, when we cannot detect the primary seat, the chances are somewhere about fifteen to one against the disease being primary in the liver. I have been very fortunate in seeing this form of disease, for I have met with three instances, and from these and others I have collected, it appears that the main characteristic of it is its extreme rapidity, for if the patient survives four months, it is almost certain that the disease is not primary in the liver, and many die before there is time for jaundice to be present. The extreme rapidity in our second case, the recent appearance of the jaundice, and the rapid enlargement of the liver made us wonder whether the disease could be primary in the liver, but the rarity of this made us hesitate to make such a diagnosis.

The first case is much more obscure. Although, as already mentioned, there are some points in favour of the view that he has cirrhosis, yet we have been able to mention several symptoms that this diagnosis fails to explain. The chief are the clay-coloured stools and the dilated gall-bladder, both of which would be easily explained if we believe that there are some enlarged cancerous glands in the transverse fissure of the liver pressing on the cystic duct. Then, too, the fact that the jaundice is deep, of a green tint, and that it has lasted many months, are all much in favour of growth rather than cirrhosis, in which disease jaundice is usually slight, and does not last long before the patient dies. The presence of the tender spots is difficult to explain on the view that the patient has cirrhosis, but if we believe he has growth, the difficulty disappears. Then, too, for some unexplained reason, portal obstruction due to growth rarely enlarges the spleen, but that due to cirrhosis frequently does. This man's spleen is not, as far as we know, enlarged. Either view would account for the ascites and lithates in the urine; so that on the whole I incline to the belief that he has malignant disease of his liver, with secondarily enlarged glands in the transverse fissure, and that as the symptoms have lasted some time, there is a primary growth somewhere out of observation, possibly in the pancreas.

It has been suggested that in this case perhaps malignant disease has occurred in a cirrhotic liver, but this is excessively rare, and the case is lasting a long time for such a combination.

It is particularly important to remember that the rapidity of our second case is quite exceptional. Malignant disease of the liver is usually a slow malady. Patients often live many months after the supervention of jaundice.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY	12, 18, 27. Mitral stenosis and regurgitation.
	15. Mitral regurgitation and ? Pulmonary regurgitation.
	16. Aortic aneurysm.
	17, 40, 41. Chlorosis.
	19. Mitral regurgitation.
	38. Mitral stenosis and regurgitation. Tricuspid regurgitation.
	46. Mitral stenosis.
PHILIP	2. Mitral regurgitation.
	23. Aortic stenosis and regurgitation. Mitral regurgitation.
	25. Aortic and mitral stenosis. Regurgitation.
	33, 38. Mitral stenosis and regurgitation.
STEPHEN	1. Mitral regurgitation.
	6. Mitral and tricuspid regurgitation. ? Aortic stenosis.
	16. Ulcerative endocarditis.
	21. Mitral stenosis and regurgitation.
	40. Mitral and aortic stenosis and regurgitation.

Nervous System.

MARY	11. Chorea.
	20. Hysteria.
	26. Exophthalmic goitre.
	34. Melancholia.
PHILIP	3. ? Pachy-meningitis.
	12. Paraplegia. Myelitis.
	22, 36. Paraplegia. Syphilitic myelitis.
	30. Double facial paralysis.
	31. Left hemiplegia.
STEPHEN	5. Fits. Cerebral syphilis.
	12. Cerebral tumour. Optic atrophy.
	36. Right hemiplegia and aphasia.
	38. Diffuse myelitis.

Alimentary System and Abdomen.

MARY	6, 43. Gastric ulcer.
	27. Pelvic peritonitis.
	37. Constipation.
PHILIP	15. Gall-stones. Hemiplegia.
STEPHEN	9. Tuberculous peritonitis.
	15. Appendicitis. Operation.

Typhoid Fever.

MARY	31, 32, 39, 42.
PHILIP	5.

Genito-Urinary System.

MARY	10, 23. Chronic tubal nephritis.
PHILIP	10. Granular kidney. Gout.
	11. Diabetes mellitus.
	18. Chronic nephritis.
STEPHEN	2. Chronic tubal nephritis.
	11, 19. Diabetes mellitus.
	14. Hæmaturia.
	18. Chronic tubal nephritis.
	28. Chronic nephritis. Hypertrophied heart. Albuminuric retinitis.

Respiratory System.

MARY	5. Acute bronchitis.
PHILIP	2. Pleuritic effusion.
	6. Bronchitis.
	9. Pleurisy.
	20. Hæmoptysis. Phthisis.
	28, 32, 40. Bronchitis and emphysema.
STEPHEN	3. Empyema.
	4. Phthisis.
	7. Bronchitis. ? Phthisis.
	13. Empyema. Phthisis.
	26. Pleuritic effusion.
	33. Double abductor paralysis of vocal cords. Tracheotomy. Locomotor ataxy.

Miscellaneous.

MARY	2. Syphilitic ulceration of tongue.
	13. Arthritis following abortion.
PHILIP	27. Gout.
	34. Tertiary syphilide.
	39. Eczema.
STEPHEN	8. Tuberculous joints.

Acute Rheumatism.

MARY	35, 48.
PHILIP	23, 35, 38.

TWO CASES OF PRIMARY EMPYEMA.

The following two cases have occurred recently in Clinical:—

CASE I.—H. B., æt. 45., was admitted on January 4th for severe pain in the right side. He had been unwell for about a week, but two days before admission he had suddenly become much worse, and the pain in the side had come on.

On admission.—His temperature was 99·4; respirations 36 per minute. The only physical signs then present were impaired resonance at right base, with diminished air entry, and a slight rub. On the same evening, pain became much more severe, and patient sat up in bed looking very distressed.

5th. Pain still worse, and extends round the abdomen to left side. A rub can now be heard all round the chest, and there is impaired resonance also at left base. Temperature 101. Patient has some cough now, and spits up typical rusty sputum, in which, however, no

pneumococci can be found. The diagnosis of pneumonia and diaphragmatic pleurisy was made. The pain was relieved by keeping patient under morphia.

6th. Temperature 101; pain much less. Patient passed a comfortable night. There is dulness below the ninth rib on either side, and over the dull areas breath-sounds are faint, but can still be heard down to the bases. Rubs still persist.

The condition remained much the same till the 8th, at 1 p.m., when patient seemed more distressed. A few moist râles could then be heard on the left side, but there were still no definite signs of pneumonia. At 5 p.m. patient suddenly got much worse, râles and rhonchi were heard all over both chests, and the pulse became rapid and feeble. At 7 p.m. a needle was put into the left chest, and sero-pus found. The left chest was then aspirated, and six ounces of foul-smelling sero-pus drawn off. This afforded no relief. The lungs became more and more choked up, and patient rapidly sank and died at 10 p.m.

Autopsy.—Trachea and bronchi full of foul sero-pus. Over the posterior surface of each lower lobe was a cavity containing sero-pus—twenty ounces on the left side and thirty ounces on the right side. No pneumonia on either side. Cultivations from the pus remained sterile.

Case II.—G. B., æt. 22. Admitted January 21st, for pain in right side. The illness began at 3.30 the preceding afternoon with sudden severe pain in the right side, but no rigor.

On admission.—Temperature 99. Patient looks very ill. Over the right base the note is impaired, breath-sounds diminished, and a few sharp râles can be heard. There is a rub in the right axilla. 10 p.m., temperature 102·4; skin hot and dry; dulness more marked. Over the eighth and ninth ribs there is marked bronchial breathing, with bronchophony and pectoriloquy. T.V.F. not increased. Patient has coughed up a little blood.

January 22nd., 11 a.m.—Signs noted last night still more marked, from eighth rib to base. Sputum typically pneumonic; but no pneumococci can be found in it. 3.30 p.m. Signs have almost entirely changed. Dulness is now absolute, breath sounds diminished and absent at base, no bronchial breathing, voice-sounds diminished. A needle was put in the eighth space and sero-pus found (just forty-eight hours after the onset of the disease). 11.30 p.m. Mr. Dunn opened the chest and removed a piece of the ninth rib. Very little pus came away at the time of the operation. The lung felt quite normal to the finger. After this the temperature fell to normal, and did not rise again. A large amount of discharge came away during the first forty-eight hours, but after this the wound rapidly closed. The tube was removed on February 1st, and patient went out on February 7th, feeling quite well. No pneumococci were found in the pus, cultivations remained sterile, and a mouse, which was innoculated, is still healthy.

The chief points of interest in these cases were:—

1. Absence of rigor in either case, although onset was sudden.

2. Presence of rusty sputum although no pneumonia was found post-mortem in the first case, and the lung felt healthy at the time of operation in second case.

3. Pneumococci could not be found in sputum or pus in either case.

4. Rapid formation of pus in both cases.

5. In Case I., the scanty physical signs, although there was more than a pint of pus in each chest.

6. The rapid recovery in Case II., after draining the chest.

7. The absence of high temperature in each case.

In the Surgical Wards.

Cases under Mr. Lucas and Mr. Howse.

Accident	4.	Strangulated inguinal hernia. Kelotomy.
	7.	Hæmatoma of cord. This, which at first formed a diffuse swelling along left cord, is now diminishing in size, forming a well-defined nodule just below external ring. Testicle is drawn up, and is slightly swollen and tender.
	12.	Compound fracture of tibia and fibula.
	22.	Circular-saw cut of forearm, with fracture of radius and ulna.
	29.	Compound comminuted fracture of tibia and fibula.
	32.	Concussion. Scalp wound. Hæmatoma of ear.
	Cot.	Small round nodule in sole of foot. ? Foreign body.

Cases under Mr. Howse.

Naaman	9.	Sinus over front of chest. Caries of ribs.
	13.	Sarcoma of testis. Castration.
	16.	Congenital syphilis. Multiple nodes.
	18.	Swelling in groin. Hydrocele of cord.
Charity	8.	Contraction after burn. Arm fixed to side of chest. Plastic operations.
	18.	Recurrent sarcoma mammæ.

Cases under Mr. Davies-Colley.

Lydia	1.	Mastoid abscess. Antrectomy.
	6.	Recurrent psoas abscess. Spinal caries.
	17.	Fibroma upper and inner part of thigh.
	18.	Patella fractured last November. Bone wired.
	22.	Cyst in breast. Removal.
Luke	4.	Cyst over outer side of elbow-joint. Operation. Cyst laid open. Elbow-joint affected with tubercular disease.
	15.	Inguinal hernia. Taxis. Apparent reduction. Persistence of symptoms of obstruction. Operation. Bowel found in inguinal canal reduced through rent in neck of sac.

CORNELIUS 5. Fractured patella. Gap of half-an-inch. Croft applied.
18. Compound dislocation of first phalanx of great toe. Adjoining ends of first and second phalanges sawn off, and bones reduced.

CASES UNDER MR. LUCAS.

JOB 2. Hallux valgus
3. Dupuytren's contraction. Varicocele. Cyst removed from parietal layer of tunica vaginalis.
4. Large cyst in floor of mouth.
17. Stone in bladder. Supra-pubic cystotomy.

CASES UNDER MR. GOLDING-BIRD.

MARTHA 4. Adenoma mammæ.
9. Large node on forehead. Excision. Transplantation of skin from arm.
12. Lipoma on shoulder. Removal.
17. Strumous dactylitis. Third toe on right foot.
18. Congenital syphilis. Enlargement of both tibiæ. Nodes on other bones. Enlargement of spleen and liver. Interstitial keratitis.
21. Incontinence of urine by night and day in a girl of 19.
22. Cleft palate.

LAZARUS 6. Ankylosis of knee, following rheumatic fever.
17. Double inguinal hernia.
18. Sacro-iliac disease. Joint opened and drained by trephining ilium over joint.
22. Ankylosis of hip. Supposed to have followed rheumatic fever.

CASES UNDER MR. SYMONDS.

JOB 11. Abscess in prostate. Prostatic calculi. Median urethrotomy. Removal of calculus.

MARTHA 14. Enlarged right lobe of thyroid. Removal of cyst.

CASE UNDER MR. LANE.

JOB 15. Cervical spinal caries. Paraplegia.

Nursing News.

WE are pleased to hear that Nurses Baker and Everton, of the Guy's Trained Nurses' Institution, who have for the past three months attended midwifery cases within the Lying-In Charity, under the supervision of a resident midwife, have successfully passed the L.O.S examination.

The Scientific Diagnosis of Nervous Disease.

I.

Ἡ δὲ κρῖσις χαλεπή (Diagnosis is difficult).—
HIPPOCRATES, *Aphorism I.*

DIAGNOSIS (worthy of the name) implies three mental processes—Experience, Observation, Judgment. Mistaken diagnoses readily group themselves into three corresponding classes. Some are due to not knowing, very many to not looking, but a large number are attributable to misinterpreting or incorrectly estimating observed and known facts. It is the last two classes which most commonly furnish a text for the regretful sermons of the deadhouse, but it is only the third class of errors which the present writer proposes to deal with now.

Experience comes with time, observation with exercise and patience, but the highest intellectual factor in diagnosis—namely: reasoning—is generally an occult process, hidden deep in the unfathomable recesses of the professor's mind. A physician, on seeing a patient for the first time (she had previously been under many physicians, and was nothing bettered, but rather grew worse), diagnosed (correctly) *hydatid of the liver*. The raw and inexperienced youths who hung upon his lips were filled with awe and admiration (having unanimously diagnosed *pleuritic effusion*), and asked how he knew it to be such—"Oh!" said the physician, "I never thought it could be anything else." Again: a married woman of forty-nine, was admitted with a tumour (noticed four or five months ago) in the lower half of the abdomen, and febrile symptoms suggestive of deep suppuration. She had borne two children. The menses had been regular and profuse all her life till nine months ago, since when they had been *few and far between*. A doctor, who had attended her for the fortnight previous to admission, was stated to have sent her up as intestinal obstruction, but the bowels had acted freely the day before admission, after an enema, and though there was nausea, there had been no sickness. All such diagnoses as these ought to be received *cum grano charitatis*. The physician diagnosed a case for section, and the willing surgeon was summoned (statim). Simpson's anæsthetic was given and a big hole made into the abdomen. The tumour, when exposed, was elastic and fluctuating. The surgeon pronounced it to be a fibroid, which had undergone cystic degeneration, and of which he had a precisely similar case the previous week, in fact a very remarkable case indeed. Seeing the course of events, the physician naturally remarked that he had felt certain it was a *fibroid* all along. *Cujus vis hominis est errare*. The anxious inquirer at the physician's elbow wanted to know how he knew it was a fibroid, when there had been amenorrhœa instead of menorrhagia the last few months. The physician replied to the effect that, if he could not

diagnose an abdominal tumour, without inquiring as to the menses, he would abandon all diagnosis for the future. (Further investigation showed the tumour to be a suppurating ovarian cystoma, which was successfully drained, and, thanks to the assiduous attention of a clinical assistant—who shall be nameless, the patient was ultimately restored to her husband and household in full enjoyment of health and happiness.) These two cases illustrate a method of diagnosis against which the writer wishes to raise a polite protest. Diagnosis by instinct, or from the thickness of the finger-nails, may seem brilliant, but for the medical *student* all such diagnoses are pregnant with a hundred pitfalls. All that glitters is not gold. There is a truth in the following words of Sir J. Russell Reynold's, universally admitted, but seldom practised:—"Do not rest satisfied with applying some little fragments of your science to the mere fragments of a case, but bring *all* your knowledge to the interpretation of *every* case, and, depend upon it, you will not often find that you have one grain too much." (*Lancet*, January 5th, 1895). On the contrary, for those who have yet to acquire both observation, *and* experience, *and* judgment, surely the only safe and certain method is the routine and laborious one of proceeding gradually in a series of narrowing circles, from the impossible to the possible, from the possible to the probable, from the probable to the actual. As a sapient teacher of anatomy has said: In acquiring knowledge of any sort, *you must work upon some plan.*

Again: consider, for instance, an abdominal tumour. One man will think he has done his duty by writing up *tumor abdominis*, and observing that we must not try to be too clever, or expect to diagnose everything correctly. Another will say, on feeling it for the first time, "Oh, it feels exactly like a movable kidney, and you see it's on the right side, and the patient is a woman; in fact, I think the best thing would be to get the table ready now, and ask Mr. Slasher to see (*i. e.*, cut into) her at once." A third will remark how exactly it resembles the cases of thrombotic hæmatoma of the suprarenal capsule described in the *Moscow Gazette* of this week. In fact, in over 87½ per cent. of Professor Popoffsky's cases, it was noted that pain was distinctly felt on pushing a pin into the ninth intercostal space on the right side, this corresponding to the spinal innervation of the affected viscus. And surgeons are just as bad (or worse). A man will calmly diagnose subdural (meaning probably, *extra*-dural) abscess, on seeing a child for five minutes for the first time in his life, and having done so, repel all further inquiry by asking what else it could *possibly* be. [After two trephinings, Pale Death stepped in, and the fount of all true knowledge, even the post-mortem table, showed the case to be one of uræmia. The temperature had been normal, and the ward clerk had reported albuminuria, but then he was only a surgical ward clerk, and, of course, did not go for much]. So with an abdominal tumour, it is so much simpler to cut down and see what it is, instead of worrying one's self to think what it *might be*. And as for that hepatic abscess, it is so exactly like the other case due to gall-stones, that I don't see how anyone could dream of mistaking it for anything else if he wanted to (the sequel showing it to be merely appendicitis, which, of course, is *obviously much the same thing, don't you think so?*) Hippocrates says that the physician "ought to meditate on these things, and with regard to diseases, ought to keep two special objects in view, namely, to do good, or at any rate to do no harm." (*Epidemics*, Book I., Sec. 5.) For all educational purposes this method of diagnosis (or rather the want of it) is wicked and harmful, to say nothing of the patient's claims.

[Superfluous as it may seem to say so, it is a fact continually forgotten or ignored, that hospitals were originally founded, not for the use and glorification of the sisters, nor of the nurses, nor of the Staff, nor of the students (all of whom, however, must necessarily be taken into one's calculations), but fifthly and lastly (incredible though it may seem) for the benefit of THE PATIENTS. And if two octogenarian old ladies *do* choose to tumble down the Approach steps on the same evening (not, of course, because they are blind and feeble, and the way is dark and slippery) and fracture their four femora in so doing, or if someone with compound fractures of base and vertex of the skull, who chances to be dead drunk and proportionately dirty as well, does happen to call at the Surgery on his way home, and is admitted, I fail to see what useful purpose is gained by scratching the dressers-for-the-week's four eyes out, though of course every *woman* who happens to be a sister or nurse feels that this is at least expected of her.]

The foregoing remarks on diagnosis appear to apply with especial force to *nervous diseases*. There are probably many men, alive and well, who have never even attempted to grapple single-handed with a new nervous case, while a good many others—in common with the writer—must have a vivid recollection of many dispiriting attempts to do so. Teachers of medicine are perfectly aware of this. Hear what hopeful words Dr. Hall of Sheffield has to say upon this point: "I know how apt a student is to try to diagnose nervous diseases *without the least thought*, hopelessly bewildered by the innumerable long names attached to them. Do not rely upon the presence or absence of the knee-jerk to the exclusion of all your anatomical and physiological knowledge, in making your diagnosis of a nervous disease; it has its own proper value and no more." (*Clinical Journal*, November 21st, 1894.)

As the difficulty of diagnosis becomes extreme, the educational value of working out, or trying to work out the diagnosis becomes proportionately great. Nor are the difficulties to be lightly minimised. One physician will be content to diagnose *paraplegia*, or *tremors*, or *fits*, or *weakness of the legs*, or *cerebral tumour* (including everything from sarcoma of the skull to syphilis of the nuclei), *without examining the patient at all.* Another, after due investigation and thought, will solemnly pronounce the case to be *a nervous condition of things.* (Considering that we are now close on to the twentiet h

century after Christ, with fifty-eight years of the Victorian era behind us, it must be clear to anyone that the time for all this sort of diagnosis has gone by long since.) A third physician will proudly diagnose some new kind of ophthalmoplegia described in yesterday's *Berliner Centralblatt;* while a fourth calmly ignores the poor patient altogether, remarking that he is a good case for Dr. Bottomless! If this is the way in which nervous diseases are to be *taught*, let alone *treated*, in general hospitals, then patient and pupil may alike congratulate themselves that there is a respectable and wealthy special hospital for both to fall back on. Of course, nervous cases do take such a time to go over properly (or improperly), and what with fetching screens, and the battery, and touch, and pain, and muscular sense, and hot and cold, and the perimeter, to say nothing of diplopia, false images, taste, smell, hearing and all such luxuries, it takes the whole morning: all of which (in the absence of rational method) is perfectly true. Nevertheless, as in other diseases, the only safe and scientific method is to examine, and cross-examine, and re-examine, every viscus and every organ, from rectum to retina, and back again (not forgetting the blood), and definitely decide which are normal and which abnormal, and sum up and give a verdict in accordance with the evidence of the majority; so in nervous diseases it is a mere matter of time and patience to examine and question every structure and every function until we have again grouped them into two camps of normal and abnormal. It is not, however, always easy to sort the symptoms when ascertained, and the plan of diagnosis which will follow is put forward by the writer simply in the hope of introducing some element of order where till lately pure chaos has (in his little life) seemed to be the rule. He is well aware of the existence of many deficiencies and imperfections, which will doubtless be pointed out. Half a loaf is better than no bread.

The following somewhat anomalous case is taken as an example:—John C., æt. 34, waterside labourer, was admitted for weakness, ataxy, and rigidity of right arm and leg. He gave the following history: Six weeks before admission he was perfectly well. Five weeks before admission he noticed numbness of the right hand, and a few days later weakness of it. Next he found he tired after walking a short distance; when walking, his right leg got stiff and rolled about, and his gait was so peculiar that his friends thought he was drunk. Since the first symptom he has felt weaker every day. A week before admission he came to out-patients, but was refused admission. There was a distinct history of syphilis six years before, so he was treated with mercury and iodide. He continued at work till three days before admission, when he gave it up because he was afraid of falling into the water whilst at work. He is exposed to all weathers, but has a comfortable home and gets enough to eat (and it might be added enough to drink also). He is unmarried, and has never been abroad.

Condition on admission.—The gait was most peculiar and striking; he walked as if in a great hurry. The right leg was carried stiffly and jerked on and off the ground at each step; the foot dragged and the toes had a tendency to catch. At each step the shoulder on the same side as the foremost foot was jerked up. Asked to pick up a pin, he could not do so with the right hand, nor could he touch his nose with his eyes shut, but in neither action was there any definite tremor or oscillation in executing the movement. There was no ataxy of the left arm or leg. Examining him in bed, there was no paresis of the lower extremities and no foot-drop. The stiffness of the right leg only comes on in walking. In the right arm there was some weakness of both flexors and extensors of the wrist and fingers; hand-grasp feeble; no apparent deformity and no rigidity to be made out; interossei act feebly. The knee-jerks were much exaggerated, and ankle clonus could be obtained on the right side, and slightly on the left. Front tap and peroneal tap also present on both sides. Elbow and wrist-jerks were readily obtained in both upper extremities; no jaw-jerk. The cutaneous reflexes were present, and the plantar were both lively. The rectum and bladder act normally. He had no pain anywhere, and sensation appeared to be perfect everywhere, with the following exceptions:—

(1). Over the palmar surface of the hand and fingers of the right side there was anæsthesia, analgesia, and hot was called cold.

(2). On the sole of the right foot, hot was called cold.

Everywhere else the following functions were quite normal—tactile, painful, and thermal sensation, localization, and sense of posture of joints. There were no vaso-motor phenomena, no wasting or trophic lesions, and the muscles reacted well to Faradism. Both eyes showed a white myopic crescent. All the cranial nerves were quite normal, there was no tremor nor nystagmus. No headache, sickness, or history of fits. No lead line, nor sign of spinal caries. There was a trace of albumin in the urine, the other viscera appeared quite healthy, and there were no enlarged glands.

A. J. S.

A large dose of Opium.

ON December 27th, at 4 a.m., I was called to a case of opium-poisoning. It appeared that the man had taken about three and a half ounces of the tincture and half an ounce of chloroform at 10 p.m. the day before. When I saw him he had vomited a very little about ten minutes previously. I washed his stomach out and removed a large amount of the opium, the water smelling strongly of it. The case terminated satisfactorily. The most remarkable part of the incident is that the poison had been swallowed six hours previously, without fatal results. He was not addicted to the drug in any form. Being only supplied in small quantities, he kept storing it for some days before the occurrence.

WALTER BUCHANAN.

Passim.

It is a solid fact that as the editorial pen is shakily carried by an icy hand, the editorial form is swathed in travelling rugs of many colours. After the manner of a famous littérateur, we may solemnly assert that solid blocks of frozen ink drop from the pen; and strenuous efforts are being frantically made by benumbed satellites to thaw the editorial mind. Meanwhile our favourite "Dalmatian" is selfishly snoozing upon the top of the only gas stove, of one candle power, which, together with an automatic gas jet, forms the only means of raising the temperature of the editorial refrigerator.

Owing to the exceptionally severe weather of the past fortnight, all Hospital Cup Tie engagements in the football field have been postponed indefinitely. It is to be hoped that our footballers will not miss the opportunity afforded them by means of the excellent ice in and around London, of keeping in good condition. To non-skaters we would also urge the importance of maintaining their form, reminding them that the best means at their disposal is by exercise in the Pavy Gymnasium close at hand.

All Guy's men will heartily join us in congratulating Mr. Tubby on his appointment as Assistant Surgeon to the Westminster Hospital, announced in our last issue. We may confidently predict for him a distinguished career in a sphere of work containing so much scope for his abilities.

The first real advance in the re-organization of the University of London "as a teaching not less than an examining body," has at length been made. Convocation has declared itself in favour of the resolutions submitted by the Annual Committee, giving general approval to the proposals of the Gresham Commissioners. Convocation has thus, after much fruitless and unprofitable discussion and opposition, brought itself into line with all the other interested bodies, such as King's College and University College. Finally, Lord Rosebery, in his replies to the deputation who recently waited upon him, both in favour and in opposition to the Gresham Scheme, has shown that he personally is desirous of moving in the right direction, and has gone so far as to say (we quote from *The Times*), "that the convictions of the Government 'point in the direction of the appointment of a Statutory Commission for framing such a scheme' as that sketched in the Gresham Report, with power to receive full representation from any of the interests involved."

Now that the Scheme is receiving the general approval of both the University and all the other bodies implicated, nothing remains but an Act of Parliament to be passed appointing the Statutory Commission, and, though considerable opposition must be expected, we can have no doubt as to the ultimate passage through both Houses of the Bill to be promoted by Lord Rosebery's Government. Commissions move slowly, we are well aware, and though the Report of the promised statutory one for the reorganization of the University of London is not likely to interfere very much with the existing relations between that body and the medical schools of the metropolis, yet we shall await its decision with a very considerable amount of interest. Of this we may be sure, that from the very nature of the Commission every opportunity will be afforded it of receiving and duly considering the diverse views expressed by those most nearly interested.

The Smoking Concert, for which a good programme has been arranged by Mr. H. M. Stewart, who will occupy the chair, is announced to commence at 8 p.m. to-night. It may be as well to remind men that the expenses are defrayed by the sale of programmes.

At the next meeting of the Physical Society, which will be held on Saturday, February 16th, in the Smoking-room, at 8 p.m., Mr. C. H. Fagge will read a paper on "Sleep."

We have been asked to remind intending competitors for the Treasurer's prize to the member of the Pupils' Physical Society who shall be judged to have contributed the best essay on "The Pathology of Dropsy," that the last day for sending such essays in to the secretaries of the Society is February 15th. For conditions of competition see Clubs' Union Blue Book, page 38.

If imitation be the sincerest form of flattery, then we may feel complimented that our new contemporary, the *St. Mary's Hospital Gazette*, should bear so close a resemblance to this journal. In the introductory article by the Dean of the Medical School, Mr. Field, who is

also Chairman of the Gazette Committee, the "new venture" is spoken of in very hopeful terms, and we can fully agree with him that the most notable effect of a representative journal undoubtedly is "its usefulness in furnishing a new bond of union between young and old." We shall be glad to see the *St. Mary's Hospital Gazette* maintaining the high standard of its first number.

On Friday last, some two dozen Guyites sat down to an excellent dinner in College, the occasion being in the nature of a farewell to Mr. Wordsworth Poole, who has recently started for Zomba. Mr. Clement Lucas, who occupied the chair, in a few cheery words proposed the toast of the evening, which was drunk in true Guyite fashion, with musical honours. Mr. Poole, in the course of his reply, expressed his appreciation of the kindly manner in which those present had received him, and added an interesting forecast of his life in Zomba. Dinner over, an adjournment was made to the Charities' room, where, after coffee and musical contributions from the Hospital songsters, the last good-byes were made, and with many expressions of bon-voyage to Mr. Poole, a memorable occasion was brought to a close.

The Committee of the Pavy Gymnasium announce that the Annual Competitions in Boxing, Fencing, and Gymnastics will take place on Monday and Tuesday, February 25th and 26th, and that a Grand Assault-at-Arms (Ladies' Night) will be held on the last day (Thursday) of February, on which occasion Dr. Pavy has kindly consented to preside. We hope that the large number of men who make habitual use of the gymnasium will come forward to help in the competitions and in the display which is to follow. Names of intending competitors should be entered on the notice posted in the Smoking-room.

The Students' Club is greatly indebted to Dr. W. H. Crosse, Chief Medical Officer to the Royal Niger Company, for the very interesting collection of portraits of several past and present members of the Hospital Staff he has so kindly presented, and which are shortly to be hung on the walls of the Dining-hall.

We have been informed that all the tickets for the Residents' Dance to be held in the Court Room on Wednesday, 20th inst., have been sold. The Residents' Dance is an annual event of such widespread popularity that the chief difficulty at times has been how to accommodate all the applicants for tickets. We understand that there is no fear of overcrowding on this occasion, as the number has been strictly limited.

At the recent Final Conjoint Examination in Surgery, out of 32 candidates from this Medical School, 24 passed.

As the official returns are not to hand in sufficient time for publication in the present issue, we are unable to give the Final Conjoint Pass List for January.

The Treasurer has been pleased to appoint Mr. Hugh Davies, M.B., B.S., and Mr. Guy E. Manning, M.B., B.S., as Assistant House-Surgeon and Assistant House-Physician respectively, in the room of Messrs. H. W. Beach and E. A. Peters, who have vacated these appointments through illness.

Never in the history of the Guy's Nigger Troupe have they been in such request as they have this season. Performances have been given in the cause of charity at Leytonstone and West Meon, Hants, in addition to those held during Christmas week. Other requests have come from Wallington, Forest Hill, Sidcup, etc., which the Troupe have been reluctantly compelled to decline, and, on going to press, we hear that, at the earnest invitation of an old Guy's man, yet another entertainment is to be given by some half-dozen members of the "Dis-Guysed" Minstrels on Monday next at Bletchingly, near Redhill. This is positively the last appearance this season of our excellent and popular Troupe, and we are certainly of opinion that they fully deserve a rest from their unselfish exertions.

Presentation to Dr. W. P. Bothamley.

Those of our readers who have the privilege of knowing Dr. Bothamley will be gratified to hear that, upon the occasion of his resignation of the post of medical officer of the eighth district of the Hackney Union, he was entertained at dinner, and a presentation of a handsome silver fruit and flower stand was made by the officers of the Union. Mr. J. Owen Perry (Clerk to the Guardians), made the presentation, and, in a brief speech, said that the gift was a genuine token of the friendship and esteem the officers had for Dr. Bothamley, and an expression of their opinion that he had proved himself a most capable and zealous officer, and a thoroughly kind and sympathetic medical adviser of the sick poor.

An Undescribed Disease.

A few cases, which have happened to come under the writer's notice in the ordinary routine existence of the past twelve months, of a malady which, though far from uncommon, finds a place in no single text-book of medical science, has induced him to try to piece together the leading phenomena of the disease, though a classical description of it would require far maturer resources of experience than any he can claim. With the exception of one or two writers on insanity, no professional text-book has yet dealt with it; it has by no means, however, escaped the attention of non-medical writers, whose descriptions frequently suggest that their authors excel rather as the possessors of a fertile imagination than of powers of careful observation. The disease is not merely a psychosis, though this is the only aspect of it which has hitherto been studied. The probable pathology of it will be discussed later, but it may here be stated that in its aggressive onset, contagious nature, exanthem and ultimate defervescence, there is much ground for comparing it with the specific fevers. It is a contagious disease characterised by cachexia, an erythematous rash, and a tendency to certain complications often of a psychological nature.

Ætiology.—A very large number of cases can be traced to a preceding case, and though no bacillus has yet been satisfactorily isolated, there is little doubt that the disease is highly contagious, as the majority of human-kind, sooner or later in their existence, seem to suffer from it. Whether the contagion is particulate or the reverse is at present disputed. A few isolated cases have been observed in which the disease appeared to begin *de novo;* such cases must, however, be regarded with ever-increasing suspicion. The proportion of the population who, having reached adult life, remain permanently immune to it must be very small.

Children, however, are quite exempt from it, and though from time to time cases presenting some resemblance have been noticed amongst school-boys, it is wiser to regard these as aberrant and atypical varieties of the disease, if, indeed, they are related to it at all. The disease is pre-eminently one of adult life, and initial attacks are commonest in the decade from twenty to thirty. The female sex appear to be somewhat more susceptible to the poison. After forty the disease is much rarer, and though undoubted examples do occur after fifty, and even sixty, these are interesting only as pathological varieties of the disease itself. Protection against subsequent attacks is not always perfect, and seems to depend much upon the severity of the initial attack and the treatment adopted.

About the vitality of the contagium there can be no doubt, for well-authenticated instances have been noticed in which the contagium has been conveyed by letters and other means over miles of country, or after lying seemingly dormant for weeks or months, and then, meeting with a suitable nidus, has again developed the disease in its complete and typical form.

Symptoms and course. — The incubation-period is variable, but is much more commonly long than short. Instances have occasionally been recorded in which it could not have been longer than a few hours, but such cases are distinctly unusual. In cases of this sort the febrile disturbance usually runs a very acute course and serious complications are common.

The onset of the disease itself is gradual and insidious, and is signalised by general malaise and anorexia rather than by rigors or vomiting. Headache and gastric disturbance not unfrequently occur. The temperature is rarely much elevated, though the pulse is invariably rapid and wiry. Palpitation is often the first symptom complained of, and is often associated with shortness of breath. Respiration is usually accelerated, and the entry of air is very often irregular. Patients often complain of a dry and choking sensation in the throat, accompanied by involuntary movements of a gasping nature. Transient attacks of aphasia are not uncommon. The patient, as a rule, complains that he is not in his usual health, but can give no indication as to which direction investigation should be directed to ascertain the seat of the disorder.

Within a few days of the appearance of definite malaise the exanthem makes its appearance. In many respects this is peculiar. It is a crimson flush, of a somewhat transient nature, which appears first on the forehead and speedily spreads to the cheeks and ears. On the rest of the body it is seldom well-marked. The exanthem has this remarkable characteristic, that it may disappear and reappear again several times in the course of the disease, especially if protracted. When the erythema is at its height the pupils are usually found to be dilated, and the pulse-rate reaches 110 or so. Sweating sometimes occurs. As the disease progresses, and in the intervals of the rashes above mentioned, the patient becomes thin and pale and the countenance becomes anxious and depressed. The ordinary avocations of his life cease to interest him, his trusted friends give him no pleasure or pass unrecognized. This apathy is not due to a blunting of his external senses, which are, on the contrary, more awake than ever. The eyes travel restlessly from one object to another, and are often directed to the patient's boots or to the floor; the ears are pricked up to hear the lightest footfall which may break upon the serenity of the patient's surroundings. Appetite is always poor, and sleep is broken or disturbed by wild and fanciful dreams.

The patient's powers of reasoning and judgment are greatly impaired, and he frequently commits acts of which he can give no intelligent explanation. The course of the disease is often protracted and is always uncertain. The termination is sometimes by crisis, but more frequently by lysis. The disease does not always terminate in recovery.

Complications and sequelæ. These have usually a psychological aspect, and when they occur, do much to recommend the unfortunate patient to the police-court

or the mad-house. Suicide is not unknown during the delirium of the initial fever.

Pathology. So far, the disease has been treated solely as a psychosis, but the above will show that it possesses many points of resemblance to the specific fevers.

Diagnosis is often far from easy. It depends mainly on the exclusion of the other fevers, on the slight alteration of temperature, on the transient and recurrent nature of the exanthem, on the disorder of pulse, respiration, and judgment, on the age and surroundings of the patient.

The *prognosis* is always somewhat uncertain. In young subjects, however, an attack which would have shattered the strength of one more advanced in life, may pass away without leaving a trace behind it. Second attacks are always milder, while initial attacks in a patient of 45 or 50 are not to be regarded lightly.

The *treatment* is mainly of an expectant nature. As in other exanthems we have no specific remedy to cut short the disease, so here we achieve most by waiting on Nature. The most important therapeutic agents are Time and Patience; change of scene is a very valuable adjunct to both of these. Some would claim to possess an antitoxin which may be relied upon to cause the disease to abort. A crisis has, undoubtedly, been precipitated in many cases in this way, but its employment has not infrequently resulted in life-long disaster, so that the remedy must be regarded as of at least equal potency with the disease. Prophylactic measures have been in some cases adopted, but with little or no success. Isolation for a time probably increases the virulence of the disease when it is ultimately contracted. Though the disease is not notifiable, news of the occurrence of every fresh case rarely remains for long a secret in the neighbourhood.

Historical references.—Hippocrates and Galen, like modern writers on medicine, do not seem to mention anything comparable to the disease as it exists in modern times. The poets, however, Greek and Latin, seem to have been familiar with the symptoms, which were prevalent equally amongst the well-greaved Achæans besieging windy Ilium, and amongst the faithful henchmen of the wily Odysseus. The latter seems to have had a bad attack when staying with Circe, and also when in Calypso's Isle. One of the most exquisite choruses of Sophocles speaks of the disease as sparing no rank nor station, but attacking rich and poor, soldier and civilian alike impartially. Horace and Catullus allude frequently to the anæmia and general cachexia engendered by the complaint. The most accurately reported cases are, however, to be found in the charming Idylls of Theocritus, where we can imagine the Sicilian shepherds and shepherdesses stricken down before the days of M.A.B. ambulances and County Councils. The Old Testament writers were acquainted with the disease. Jacob seems to have had it in a chronic form for fourteen years, whilst the Psalmist was a victim of many recurrent attacks of a severe nature. Cases will also be found in the Arthurian legends and in many modern productions of an ephemeral nature. The present writer is content to leave to others the task of naming this interesting malady.

Ἐρῶς.

The Defence of the First Permanent Molar.

The statistics concerning 30,000 teeth extracted at Guy's, compiled by Messrs. Pare and Wallis, at the suggestion of Mr. Maggs, show that the first molar heads the list of extracted teeth; but it is to be hoped that the friends of this particular tooth will protest against the deduction drawn "that the first molars are those most liable to be lost early, and that their extraction in crowded mouths for regulation purposes is to be preferred *cæteris paribus*."

Before we condemn the first molars as permanent teeth, we must ask ourselves how many of them were extracted because they could not be saved, and how many were good teeth removed merely for the sake of making space. For reasons that need not here be mentioned, it is usual to find crowding of the teeth at the age of twelve, which is the period when remedial treatment by mechanical means would probably be commenced. If a first molar at this time is at all carious, it has been the rule to extract it, and very many dentists adopt the principle that if one first molar be extracted, all four should be extracted. Others go further still, and make it a matter of routine to extract all first molars, carious or sound, at the age of twelve. They argue that first molars show a disposition to decay earlier than the bicuspids, forgetting that the molar was erupted long before the bicuspids, and its early years were passed under very unfavourable conditions, owing to the prevalence of decaying temporary teeth and stumps, of which the mouth becomes rid by the advent of the bicuspids. Unfortunately for the first molar, its nature as a permanent tooth is rarely recognised by the patient till too late, and many dentists do not attempt to save the tooth even in the earliest stage of caries, under the assumption that the tooth must inevitably be lost—a forecast which is only justified by those who never spare a first molar at the age of twelve.

Of latter years this molar has found many friends who, by preference, sacrifice a bicuspid to relieve crowding, and who repudiate the idea that if you extract one molar you should extract all four. The loss of a bicuspid relieves crowding of the front teeth more quickly, for the space created is further forward, and there is the great additional consideration that the removal of bicuspids will in many cases obviate the necessity of wearing a correction plate.

I think that in extracting for space each tooth should be considered on its merits, and a first molar that has survived to the age of twelve without considerable caries should be looked upon as likely to prove a very permanent tooth. In justice to the claims of the permanent molar, the teeth of children should be kept

under observation from the age of four. The temporary teeth should be filled, and this alone will go far towards saving the first molar from caries by preventing the decomposition of food and the formation of acids in the mouth. The preservation of the temporary teeth will enable the child to masticate its food, and will preserve due space for the corresponding permanent teeth. The use of the tooth-brush cannot be adopted too early in life.

I fear that many years will elapse before our patients and our out-patients become alive to the necessity of early dental treatment, but if ever that time should come, a revision of the statistics relating to extracted teeth will acquit the first molar of the reproach that at present rests upon it so unjustly.

January 29th, 1895. F. NEWLAND-PEDLEY.

An unusual Case of Herniotomy.

A. W., æt. 23, a healthy agricultural labourer, been ruptured a great many years. His mother says patient was seen by a doctor when seven years old, who said it was a rupture, but she never got a truss for him, and he has never worn one.

Monday, December 31st, 1894. He had been to work all day straw-carting, and had a very hearty dinner, feeling quite well. During the evening he complained of pain in the abdomen, and sickness came on in the night. His bowels had acted in the early morning. From this time he was constantly sick, and the hiccough was very severe. Pain very acute, in the umbilical region especially.

I saw him on Thursday morning, January 3rd (fourth day of strangulation), and found a right sided inguinal hernia with all the symptoms of strangulation; constant sickness; hiccough, constipation, and no flatus passed by bowel. I tried taxis, but without making the least impression on the hernia, although it gave distinct impulse on coughing. I made arrangements to see him again in the evening to operate. A. C. E. mixture was very ably administed by Mr. P. Wilmot, and Dr. A. R. Manby gave me his valuable assistance.

I proceeded to do an ordinary herniotomy, carefully dividing all tissues until the sac appeared, which was unusually thick and dense. On opening it, about half a pint of blood-stained peritoneal fluid escaped, and the gut appeared quite healthy and flaccid, and had not the least appearance of being strangulated. I passed my finger up the canal and through the internal ring, but no stricture was felt. It was now quite apparent that it was no ordinary case of hernia with which we had to deal, and it was equally evident that the piece of gut in the hernia was not giving rise to all the urgent symptoms of obstruction. I then passed my index finger along the bowel deep into the abdomen, and upwards into the umbilicus. I could then just reach with the very tip of the finger a very tight constriction, through which a small loop of bowel could be felt.

I decided to at once open the abdomen towards the part in which I felt my finger-tip pass into this well-defined ring. I kept my finger in the opening, and used it as a guide and director, dividing the abdominal wall right up to the constriction. We had then the satisfaction of seeing the purple-coloured and strangulated portion of the bowel, which dropped back into the abdomen after dividing the sharp edge of the ring. The ring was very sharp and well-defined, and felt as if it were in the wall of the abdomen—I have no doubt it was formed by the fascia transversalis.

The wound was sewn up with silk sutures—peritoneum to peritoneum—and silver wire was used for the skin, the dressings used being iodoform, carbolized lint, and absorbent cotton wool, fastened by a Spica bandage. One-third of a grain of morphia was given hypodermically. Diet, a teaspoonful of milk only at intervals.

January 17th. Wound completely healed. Patient allowed to get up.

The interesting points to be noted in this case are:—

1. Although there was an irreducible hernia, it did not give rise to the urgent symptoms of obstruction.

2. The rapid way the patient got well after relieving the bowel, the temperature never rising above 99.

3. The very tight tendinous ring through which the bowel had slipped and become strangulated.

I was certainly fortunate in being able to feel the ring causing the strangulation before opening the abdomen, and was thus able to use my finger as a guide.

East Rudham, Norfolk. H. E. ROWELL.

Two Cases of Malignant Disease of the Thorax.

MALIGNANT disease of the thorax is not a common disease, and the two annexed cases are good illustrations. They are published by kind permission of Drs. Rawlings and Knight, from notes by my colleague, Mr. J. Urwin, M.B.

CASE I.—Was at first considered to be a case of old pleurisy—possibly empyema. The loud systolic murmur under the left clavicle was found to be due to a mass of growth pressing forward the subclavian. He had a very deeply-coloured skin, the nipples especially being almost black, which suggested Addison's disease.

E. M., æt. 32, boiler-maker. Admitted for pain in chest and weakness of legs. Illness commenced four months before admission. Had severe cold; pain in chest came on suddenly and gradually increased in severity. Very little cough or expectoration. Left work four days after pain commenced, and had to go to bed. Pain got worse up to admission. Lost much flesh.

Family history.—Good.

Previous history.—Good.

Condition on admission.—Skin dark; evidently lost much flesh. Temperature 99·2. *Respiratory system.*—Very little cough; no expectoration. Pain in left side and shoulder. No breathlessness. Left side almost

immovable; right side moves more than normal. T.V.F. absent on left side; well-marked on right. Absolute dulness over whole of left side, front and behind. Breath sounds almost inaudible below level of nipple. Tubular breathing under clavicle. *Circulatory system.*—No apex-beat apparent; cardiac dulness involved in dulness of left chest. Heart-sounds normal; second sound accentuated at base. Immediately below left clavicle a loud systolic, blowing murmur can be heard over an area extending from edge of sternum outwards almost to anterior fold of axilla. The heart-sounds can be heard over almost the whole of the left chest in front and behind. Other systems normal.

October 31st. Left chest explored with needle; nothing obtained.

November 7th. Soft swelling in posterior part of left axilla. Exploring needle inserted, but nothing obtained.

27th. Murmur below left clavicle very loud. Pulses unequal; the left much smaller than right.

December 4th. Pain in second right metacarpal bone and front of both tibiæ. Lumps in all these positions.

17th. Similar lumps on both radii.

24th. Great pain in thighs. Glands in both Hunter's canals enlarged.

31st. Two lumps as big as hen's eggs over dorsal spine.

Patient got rapidly worse, and died on January 7th.

Autopsy.—Numerous enlargements on the bones, tibia, radii, ulna, humeri, ribs (right side). *Chest.*—On opening the chest, a large mass found to occupy the whole of the left side, the heart being displaced slightly to the right. The mass extended just beyond the limits of the left pleura. When cut into, showed first a thick, firm layer varying from about one and a half to two and a half inches thick (pleura), enclosing the remains of the lung. This mass has gone through some of the ribs, the whole breadth of the rib being absorbed. Right lung normal, but visceral pleura showed abundant small whitish growths. *Pericardium.*—One or two small growths on visceral pericardium, *Abdomen.*—Liver normal, except for one or two small superficial growths. Other organs healthy. The growth on bones found to come from periosteum. Histologically, growth was a sarcoma.

Case II.—This case was at first looked upon as one of phthisis.

T. N., æt. 26, labourer. Admitted October 8th, complaining of pain in chest, with cough and expectoration.

History present disease.—Two and a half months ago got wet at his work, followed by pain in chest and weakness. Cough began about twelve weeks ago, accompanied by hæmoptysis. Getting worse. Expectoration not increased. Pain in left lung commenced twelve weeks ago.

Previous history.—Good.

Family history.—Unimportant.

On admission.—Patient complained of much pain across chest. Much coughing, and a fair amount of muco-purulent expectoration. No blood. Has a worn-out look. Sweats much at night. *Respiratory system.*—Much cough; moist, causes a good deal of pain across front of chest. Percussion shows dulness at left apex, extending downwards till it merges in cardiac dulness. Breath-sounds indistinct.

November 4th. Lump in right side of sternum—first noticed yesterday. Much weaker.

17th. Growth about size of a walnut, very tender.

Patient gradually got weaker, and died on December 5th.

Autopsy.—Chest.—Left bronchial glands much enlarged. Upper lobe of lung collapsed. Glands on right side slightly enlarged. Glands pale and firm. Growth on sternum from periosteum. Right lung normal. *Abdomen.*—Liver much enlarged (weight ten pounds), showing numerous large nodules, greyish in colour, firm, and umbilicated both on upper and lower surfaces; also general infiltration of liver substance. Tail of pancreas enlarged.

Swansea. S. G. FLOYD.

Dr. Nevins' Jubilee.

Dr. Nevins (whom many will remember was a very distinguished student at Guy's, and took the M.B. Lond. in 1841, and became medical tutor in the Hospital) has just completed his jubilee year of membership of the Liverpool Medical Institution, and at their ordinary meeting on the 17th ultimo the members took the opportunity of offering their congratulations upon the event. The motion was made by the President, Mr. Chauncey Puzey, F.R.C.S., who said *(inter alia)* that since Dr. Nevins had been in Liverpool he had led a busy and useful life in connection with the Medical School, the Eye and Ear Infirmary, the School for the Blind, and other charitable and scientific societies. Dr. William Carter, who seconded the resolution, said that Dr. Nevins, although a man of strong convictions, and impelled to bear a part in many controversies, had never made a personal enemy. The resolution was carried by acclamation in an unusually large meeting.

Dr. Nevins, who seemed to be in the best of health and of mental and physical vigour, expressed in most happy terms the pleasure the resolution afforded him.

Dr. Nevins is now, for the second time, President of the Literary and Philosophical Society. His active sympathy with schemes of charity and benevolence is widely known. He has been most successful as Secretary of the Medical Benevolent Fund, an office he has filled for many years, and he was appointed Consulting Physician to the Stanley Hospital at its inception, now nearly thirty years ago.

Guild of S. Barnabas for Medical Students.—Meetings first Wednesday in each month, at S. John's, Red Lion Square, W.C., at 6.15 p.m. For particulars apply to—The Chaplain, 35, Brooke Street, Holborn, W.C.; or to The Secretary, 14, Woburn Square, W.C.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Specialism in Medicine.—A Reply.

SIR,—With apologies for troubling you, I should like an opportunity to answer the letters commenting on my article on Specialism.

Mr. Williams says the experience of a specialist must necessarily be of more value than that of a man who sees fewer cases of the same type. To me the contrary of this is obvious. Can Mr. Williams mention any single disease that an out-patient physician, who sees all cases as they come along, would not have experience enough to detect? I can think of none. The complaint once decided, then, as I said, the treatment of it is either surgical or medical, and would be provided for by a staff formed on the lines I suggested.

If in Mr. Williams' next paragraph you read for "distinguished physician,"—"distinguished-upper-air-passage specialist," I quite like the tale, and hereby thank your correspondent for teaching me that now, which drives home my contention admirably. Only a partisan interpretation of my paper could assume that I wanted every student to leave hospital knowing all things relating to disease; that would be a manifest absurdity! But my question remains still to ask whether the student is likely to get a better grasp of what he does learn from a teacher who looks at his patient as a man, or from one who sees in his case merely an object accidentally attached to an ear, nose, throat, or one that happens to be inside a "skin."

I have never seen (nor, I take leave to think has Mr. Williams, outside the realms of nightmare) an out-patient physician attempt to demonstrate "every part of the human frame to a crowd of students." On the contrary, physicians of my acquaintance always drew attention to a bruit, or a rub, or whatever might be the salient points of the case. Clearly, if there are more out-patients than one man can attend to, two are required, or, as Mr. Williams puts it—again unconsciously pleading my cause—"There was an imperative call for a division of labour" . . Quite so, and I merely propose to divide the labour, instead of dividing the patient, and to let the student always see the work done as he ought to do it, nay, as he will be obliged to do it in the normal practice.

And again, the sting in the tail of Mr. Williams' letter seems to me to be turned against his own cause. I judge that he agrees with me therein that the exclusion of specialism from the hospitals is as desirable as the advent of the millenium. Again, quite so. Taking advantage of the elasticity of the unknowable, I would suggest a liberal acceptation of the term millenium, and hazard a guess that, whatever it is, it is coming all the time in bits—it will not burst upon us all of a golden afternoon. And so far as its arrival in our hospitals is concerned, I would have Mr. Williams believe that an instalment of it is at hand, if we would face the matter squarely in the ending of specialism.

Touching the other letter, I am afraid Mr. Hopson and I contemplate opposite sides of the shield, and are likely to remain eventually unconvinced. If he thinks I disparage, or wish to disparage dentistry, he sorely misunderstands me, and I regret it. I regard dentistry as an admirable and honourable occupation. But it is not surgery. And I am bound to say that Mr. Hopson's catalogue of the qualifications demanded of a dentist—though it awes me some—yet leaves me cold. To me dentistry means the extraction, preservation and regulation of teeth, and to discharge these offices faithfully, no more requires a comprehensive knowledge of medicine, surgery and midwifery than does the care and adornment of the hair. A man, I am aware, may take his M.R.C.S., or even his F.R.C.S., before commencing the practice of dentistry, but so may he go into training for climbing the Matterhorn before he tackles Hampstead Heath or the Whispering Gallery at St. Paul's; and if he subsequently confines his efforts to these lesser and safer eminences, the Matterhorn would, in time, wind him, and, saving your presence, funk him too. And so, if such person turns aside from his F.R.C.S. to the extraction and excavation of carious teeth, I should ask to be excused calling him in to tie my carotid artery at a pinch, although the law called him a surgeon and physician, many-lettered. Mr. Hopson misunderstands me utterly. I named the word dentistry merely to illustrate my contention, merely to show that the terms dentist and surgeon are non-interchangeable.

I trust Mr. Carpenter's susceptibilities about the honour of his profession will be allayed by my reply to Mr. Hopson. The point under discussion is not whether general practitioners are, or are not, *good* all-round men. All-round men they must be, and the question is how to make them as good as may be. As to the moral to be drawn from Mr. Carpenter's cases, I am not so clear, but, granting for the sake of argument that an army doctor does, or did exist, who is unable to extract teeth, and that there is a general practitioner who requires the aid of a specialist to discover "that the tissues and adjacent inflammation" were due to an impacted lower wisdom tooth—the moral I should draw is that students preparing for general practice should have a good knowledge of dentistry, and that, therefore, those desirous of becoming "specialists in the profession of dentistry" should have schools of their own. If this is what Mr. Carpenter means, then we are absolutely agreed, and I have to thank him also for illustrating and emphasising my original proposition. If he means specialisation being "essential to a high standard of excellence in any department of work," that every practitioner must have a mob of specialists in attendance to correct his blunders—as for instance the two patients snatched from death by the timely appearance of a dentist—then I'm afraid I shall not be counted among his followers. This latter reading, also, would be a still more eloquent plea for my suggested reforms, for which I am grateful.—I am, etc.,

S. W. MACILWAINE.

Reviews.

A Text-book of the Physiological Chemistry of the Animal Body, including an Account of the Changes occurring in Disease. By Arthur Gamgee, M.D., F.R.S. With Illustrations. (London, Macmillan & Co.). 2 vols. Price 18s. each vol.

The first volume of this most valuable work appeared in 1880, and although since that date several books have been published upon the same subject, none of them can be said to have covered quite the same ground. The author states in the preface to the second volume that he is engaged on the preparation of a new edition of the first, volume and its appearance will be looked forward to with great interest, for when it comes out, the student will be provided with a treatise quite up to date, upon the physiological chemistry of the elementary tissues, and of digestion. In the second volume, the author in the first place deals with saliva and its action upon food; and under this heading he gives a brief account of the excretion of drugs in saliva, and with the changes which this secretion undergoes as the result of disease, considering also the mode of formation of salivary concretions and of the tartar of teeth. The second chapter treats of gastric digestion, and to this is appended a most interesting and valuable account of the effect of disease upon this process, which may be warmly recommended to the notice of physicians, in consequence of the important bearing which it has upon the diet most suitable for patients suffering from diseases in which the functions of the stomach are interfered with. Then follow chapters upon the physiological chemistry of the bile, and upon a most difficult and fascinating subject, namely, the mode of production and the phenomena of jaundice, upon the changes which the bile undergoes in disease, and upon the mode of action of cholagogues. Upon this last subject the author considers that there is much need for further investigation. The remaining chapters, with the exception of the last, deal with the physiological and pathological chemistry of the small and large intestines, together with the rôle played by micro-organisms in the alimentary canal. The last chapter treats of the comparative physiology of digestion, a subject about which comparatively little is known, but which is of the greatest importance on account of the side lights that it may throw upon the processes that occur in the alimentary tract of the higher animals. Enough has been said to show how far reaching is the scope of the book, and how great is the service which the author has rendered, not only to the physiologist, to whom he naturally especially appeals, but also to the scientific physician.

A Monograph on Diseases of the Breast, their Pathology and Treatment, with special reference to Cancer. By W. Roger Williams, F.R.C.S. (London, John Bale & Sons). Price £1 1s.

It is quite refreshing, in these days of condensed literature, to come across a book in which the author has allowed himself to discuss his subject at length, and from various points of view. The result has been to produce a volume which, instead of being a dry record of facts, is as interesting as a modern novel. The greater part of the book is occupied with cancer of the breast; but the other affections of the organ are also treated with considerable detail. The most interesting chapters in the book are those devoted to heredity, geographical distribution, pathogenesis, and similar subjects. As these matters are not dealt with at much length in most books, these chapters are of special value, and will be read with much interest. The one upon pathogenesis is, however, disappointing in many respects; for although the author mentions the recent work which has been done upon the subject, yet he dismisses it in a somewhat cavalier style, and does not seem to attach nearly as much importance to it as it undoubtedly deserves. Further, in another respect we think that the book might with advantage be extended, and that is with regard to treatment, as the attention given to this important branch of the subject is occasionally very scanty and frequently somewhat inadequate. The volume is well printed on good paper, and with clear readable type, whilst the illustrations are, on the whole, good and carefully chosen.

Urinary Surgery. By E. Hurry Fenwick, F.R.C.S. Eng. (Bristol, John Wright & Co.). Price 4s.

A brief but useful summary of the recent work upon the surgery of the urinary organs. No attempt has been made to write a memoir upon the subject; all that the author professes to have done is to have collected the papers upon the surgery of the urinary organs, and to have summarised them for the benefit of those who have not ready access to the originals. In addition, however, these pages show that the author himself has written much upon the subject during the last few years. This is evident from the frequent references to his own writings that are profusely scattered through the book. The value of the volume is much enhanced by the fact that it is furnished with full references to the many papers consulted in its preparation.

The Clinical use of Prisms and the Decentering of Lenses. By Ernest E. Maddox, M.D. Second edition, revised and enlarged. (Bristol, John Wright & Co). Price 4s. 6d.

The fact that this book has reached a second edition during the space of four years shows that it has met a distinct want, for from the nature of the subject, it can only appeal to a limited number of readers. The title does not quite, however, convey all that the book describes, for in addition to a fairly full account of the uses of prisms in the treatment of refraction cases, and of cases of faulty convergence, there is a chapter upon the clinical application of prisms in diagnosis, containing useful hints for the use of prisms as an aid to the diagnosis of obscure nervous affections in which the ocular muscles are affected.

From the Gazette's Special Pathologist.

All specimens — particularly those of solid tissues — should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

A., Wellingborough.—No tubercle bacilli could be found.

A. H. W., St. Leonards.—No tubercle bacilli present.

H. V. R., Fordingbridge.—The tumour consists of uterine muscular tissue permeated by large vessels. Its surface is covered with columnar epithelium, which dips into the substance of the growth; but there is no evidence of malignant disease.

E. W. A., Tunbridge Wells.—No tubercle bacilli could be found in the sputum.

C. D. M., Bournemouth. — Specimen of sputum showed no evidence of tubercle bacilli. There are considerable numbers of large putrefactive bacilli present.

C. M., Ilminster. — Albumin and sugar absent. Blood: no chemical reactions for hæmoglobin. Deposit was extremely small in amount. After centrifugalizing the minute residue obtained consisted entirely of red blood corpuscles with a few granular leucocytes. No casts of any kind.

W. H. M., Kidderminster.—The tumour is a sarcoma composed of round and oval cells. It is situated in the subcutaneous tissue, and does not invade the skin and corium.

W. H. M., Kidderminster.—Sections of the wall of the cavity in the testis are lined with granulation tissue, which is caseating in places. This condition, taken with the naked-eye appearance of the specimen, is sufficient to indicate its tuberculous nature.

G. F. H., Balham.—Tubercle bacilli are present in considerable numbers.

F. K. H., Hampstead.—Acid, 1029; sugar and blood absent; albumin 0·75 parts per mille. Calcium oxalate as in morning specimen, but no free uric acid; the place of the latter was taken by amorphous urates; no casts of any kind could be found. The morning's specimen was absolutely free from albumin, so that its presence at the end of the day is certainly a striking circumstance. The evening sample, however, showed no other evidence of nephritis.

F. K. H.—(Early morning). Reaction acid, 1019. Albumin, blood and sugar absent. The deposit was very small in amount. It contained a proportionately large number of calcium oxalate crystals, and a few of free uric acid. There were no casts, and no other constituents of importance.

F. D. A., Sutton.—No tubercle bacilli can be found in the sputum.

H. W. D., Croydon.—The wall of the sac is composed of tough fibrous tissue without special lining membrane. In the outer layers of the wall are lobules of glandular tissue consisting of acini and well-marked tubules lined with columnar epithelium. The source of these is not apparent, and there is no statement whence the specimen was derived.

A. R., Lewisham Hill. — The specimen was too much decomposed for satisfactory examination, but there were no marked signs of disease in it.

W. A. G., Chatham.—The growth in the portal fissure of the liver is composed of enlarged lymphatic glands, which are stuffed with miliary tubercles. There is much surrounding inflammatory tissue, by which the portal vein and hepatic duct are compressed.

PATHOLOGIST.

A Great Discovery!

The following is the text of a letter which was received a short time ago by Dr. Perry, at the Medical Office:—

"Gentlemen,

"I herewith submit my paper for experiment to the Medical Staff of your Institution on the cure of Phthisis, or Consumption, set forth by the following means hereafter named.

"Item 1.—Get a mad dog, shoot it, extract its teeth, and chemically extract therefrom the poison, or Hydrophorbiac virus. Inject the virus subcutaneously into the consumptive patient after which virus has began to take effect, and working in the blood of the patient to a white fever heat or ferment. Then send off immediately the person to M. Pasteur's Institute, Paris, to undergo treatment in the ordinary way for cure of Hydrophobia. With the cure of Hydrophobia simultaneously carries with it the cure of Phthisis. The one powerful agent burns out the other completely, leaving the patient sound and free from both diseases. A case in point came under my own observation and knowledge some twelve months ago (details later on), pointing beyond a doubt the efficacy of some such remedy in this direction for the cure of Tuberculosis, Athrophial wasting of the body by expectoration of the lungs through the cough. With regard to Fox and Cat virus, the same results equally apply. The remedy solely depends upon the certainty of M. Pasteur's cure of Hydrophobia. The

most important object by this process is to induce or develope in the system the strongest rabies; this depends upon the most active and virulent virus obtainable. As I purpose ultimately placing the remedy in possession of every hospital in Great Britain and Ireland, I am very solicitous, however, for some reasons that your institution should have the honour of proving and demonstrating to the world the certain test and cure of this most insiduous disease.

"I wish, at the outset, particularly to enjoin upon you absolute secrecy in this proceeding, trusting that my name will be suppressed on all occasions (for a time) in connexion with the remedy and cure until the experiment has been tested and proved effectual or otherwise. I leave it in your hands entirely, with a hope that it may prove a success.

"Yours sincerely,
"H. G. P.
"Noviciate in Chemistry and Pharmacy."

Notices.

THE "VIKING" BRAND OF CONDENSED MILK.

The "Viking" Brand of Condensed Milk—a specimen of which we have received from the Norwegian Milk Condensing Company, Botolph House, Eastcheap—differs from others in the market in not containing any admixture of cane-sugar. It is prepared by a special process of condensation invented by Olav Johan Olsen, M.D. Analyses which have been made of this milk show that it is pure unskimmed cow's milk concentrated, and that no preservative has been added, the keeping qualities of the milk depending on the special method of manufacture adopted. It has evidently undergone very little change by the process of condensation, and can, therefore, very well replace ordinary milk for household use. It would appear that this milk is especially suitable for the use of infants, on account of the absence of cane-sugar, the large proportion of which, in some brands of condensed milk, renders the addition of an undue quantity of water necessary.

Guy's Hospital Rifle Association.

THE general meeting of this Association—the first since its incorporation as a constituent institution of the Clubs' Union—was held in the Anatomical Theatre on the 31st ult., the chair, in the absence of Mr. Dunn, being taken by Mr. Fripp.

The rules formulated in the "Blue Book"—to which all men interested are referred—were formally adopted, and the following officers for the ensuing year elected:—President: L. A. Dunn, Esq.; Captain: H. Fulham-Turner; Secretary and Treasurer: S. H. Mason; Committee: W. E. Secretan, W. H. M. Telling, G. Bedford, R. H. Ashwin, H. Fulton.

A vote of thanks to the Chairman concluded the proceedings.

Viva Voce for Elementary Biology.

"CONJOINT."—JANUARY, 1895.

"What is that under the microscope?" (spirogyra).
"How do you recognise it?"
"What is the green colour due to?"
"How does it differ from an animal cell?"
"Has this cell a nucleus?"
"Where is it situated?"
"What is under this microscope?" (section of hydra).
"Is it a transverse or longitudinal section?"
"What is the difference between this and the amœba?"
"What external apertures are there in the earthworm?"
"What is under this microscope?" (protococcus).
"How do you recognise it?"
"What is this?" (a dissected dog-fish).
"Is this a male or female?" (female).
"Why?"
"What is this?" (oviducal gland).
"And this?" (oviduct).
"Describe the heart of the dog-fish."
"Yes." "And the circulation?"—[*Bell.*] H. C. B.

Appointments.

BURTON-BROWN, Surgeon-Capt. F. H., has been appointed to the medical charge of the 43rd Goorkha Rifles.

BUTT, Dr. F. K., has been appointed Surgeon to the Bengal Presidency Volunteer Rifle Battalion.—*Calcutta Gazette*, January 12th, 1895.

BUTT, Dr. F. K., has been appointed Medical Inspector of Seamen for the Port of Calcutta.

MORRISON, J. T. J., M.A., M.B. Cantab, F.R.C.S. Eng., has been appointed to the Chair of Surgery in the Mason Hall, Birmingham.

PEARCE, A. CHANING, M.B. Lond., has been appointed House-Physician to the Victoria Hospital for Children, Queen's Road, Chelsea.

PUZEY, CHAUNCEY, F.R.C.S., L.M., L.R.C.P. Lond., has been re-appointed Honorary Surgeon to the Liverpool Northern Hospital.

ROBINSON, W. E., has been appointed Resident Medical Officer to the Stoke Newington Dispensary.

Births.

BLIGH.—On December 30th, at the Garlands, Caterham Valley, Lilian Josephine (*neé* Lafone, L.O.S.), the wife of William Bligh, M.D., B.S. Lond. etc., of twins—boy and girl.

SWAYNE.—On January 16th, at Leicester Place, St. Paul's Road, Clifton, Bristol, the wife of Walter C. Swayne, M.D. Lond., of a daughter.

EDITOR'S NOTE.—We much regret the mistakes which occurred in our report of the very excellent paper read by Mr. Spriggs before the Physical Society. The most notable among them was in the title, which should have read "Food" instead of "Foods."

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

FEBRUARY 23, 1895.

Sacro-Iliac Disease.

CLINICAL LECTURE BY MR. GOLDING-BIRD.

THE subject of to-day's lecture being a case of sacro-iliac disease, it has been suggested to me that a clinical survey of the various causes—at least the more common ones—that should be remembered at the bedside when hearing the story of a pain in the back, might be of some service. Though not an exhaustive or systematic list, yet the more common producers of rachalgia will now be noticed; but let me first say that the connection between them and sacro-iliac disease is really close, for the latter malady, before it reaches the surgeon's care, in most cases runs the gauntlet of medical—and if a woman, of gynæcological—treatment, its earliest symptoms being generally very vague pains, as likely referable to "medical" sciatica as to some uterine trouble when the back is complained of. Of the various rachalgias, I would remind you of—

(*a.*) *Lumbago.*—A lumbar pain unaccompanied by muscle rigidity or any other objective sign, which, whilst allowing its victim to stoop, makes the act of straightening simply acute torture. The more acute form is undoubtedly rheumatic, yet it may be very sharp when produced by gonorrheal pyæmia—so-called gonorrheal rheumatism. In the early stages of syphilis—the great pox—there is a marked backache, as there is in the onset of variola—small-pox. Inasmuch as these three last do not so obviously give rise to pain on rising more than on stooping, we may class them as rachalgias as against true lumbago.

(*b.*) *The irritable spine of young people.*—Mostly in nervous girls, where the slightest touch on the spinous processes provokes most marked manifestations of acute pain. There is, too, more or less constant backache, but the spine, on examination, presents nothing abnormal, unless slight lateral curvature. It is supple, and there is no muscle rigidity. The patient can stoop and raise herself with equal facility.

I may remind you that in every one the fifth cervical vertebra gives decided pain where pressure is made on its spine. I have known a patient condemned in consequence for cervical caries.

(*c.*) *In kidney disease* vague lumbar pains may be complained of, but if they can be localized it will be found they proceed from points on either side of the spine, not from the spine itself—other circumstances, however, must determine their diagnostic value. I have known a case of senile spinal tuberculosis—at over æt. 70—taken for renal disease; and constant exercise being ordered brought matters to a climax in a month's time!

(*d.*) *Tubercle of the spine.*—Where no deformity exists, early caries is not always easy to diagnose, but it is too large a subject to dilate upon now. Cancer of the spine, though rare, must be remembered in later life; its pain is most acute.

(*e.*) *Aneurismal erosion of the spine.*—To judge by post-mortem appearances the suffering ought to be most severe, yet in many a case of aortic aneurism, though extensive erosion has happened, there are no subjective symptoms of it; at times,

however, the backache is most severe, and this, with local dulness and perhaps slight lateral displacement, will aid in forming an opinion, where other signs of aneurism exist.

(*f.*) *Uterine displacements*, and other uterine and ovarian disturbances, are commonly accompanied by constant and wearing backache low down, and I know of a case of sacro-iliac disease in which the pain was regarded as of uterine origin. Exercise increases the pain, but the patient can stoop, and the spine is in no way fixed. Other symptoms, however, than the rachalgia must give the diagnosis. I remember a former obstetric physician to this Hospital (Dr. Phillips) teaching us, when I was in the Charity, that in some uterine backaches there was a curious form of headache occupying an area like a small tonsure at the top of the head, but do not know whether it is a symptom of real clinical value.

(*g.*) *In malignant disease of the rectum*, or of any part where the lumbar glands are likely to be involved, a persistent rachalgia raises strong suspicion of secondary deposits.

(*h.*) *Coccygeal pain*, it is true, can hardly be fairly called backache, yet patients euphoniously thus describe their suffering, it requiring often a few leading questions in order to elicit the true location of their pain; and under coccygeal pain you must not think only of diseases of the coccyx, which a local examination will generally discover, but there is a true neuralgia of the part—a coccyodynia; also pain starting from there and extending up the back may be produced by piles, fissure, and other lower rectal affections.

(*k.*) *Hip disease*, in its chronic stage, when from joint flexion there is marked lordosis, will at times cause great pain in the lumbar region, so much so that you have to be careful to eliminate, in making a differential diagnosis, the possibility of a spinal deposit of tubercle as well as of one in the hip, but, fortunately, the double affection is not common.

This mention of hip disease will connect what I have been saying with the disease mentioned as the subject of my lecture. I hardly know why, but it always seems the fashion to contrast sacro-iliac disease with that of the hip joint, and yet, in reality, a very superficial examination serves to differentiate the two. A limp in walking, the vague statement of pain about the haunch generally, and a pain down the leg to the knee (obturator pain) are the symptoms that may be regarded as common to both, but now they diverge very markedly. The stiffness of the hip, whether articular or from muscle rigidity, and the finding of local pains and local thickenings, show it to be a hip case; whilst the true local pain of sacro-iliac disease is far removed from the hip, and the referred pain, whilst it may be of obturator character, is more likely to be a genuine sciatica.

In the case before us, that of a man, æt. 29, now in Lazarus, he had for a year sought relief on account of sciatica that made him lame. He had had the best medical advice, and had even been in our medical wards. Electricity relieved him a little, but he did not lose the pain until, coming under Mr. Lucas's care, he was ordered a plaster of Paris spica. This he has long worn; but as he has had to remain out of work, and though free from much of his pain, has become very cachectic, and is getting worse, he again has been admitted to see if things can be made better for him. When we examined him upstairs, we found a delicate, though well-framed, young man. He could limp with difficulty, but as he lay in bed he was practically free from pain. The left leg and buttock were much wasted from disuse; but at first nothing else was to be made out, no abscess, nothing objective whatever. Turning him over, however, pressure was firmly made over the sacro-iliac joint, and this at once elicited a local pain which he associated with the sciatica he used to have. Pressing outwards the two anterior iliac spines gave pain in the same place. A closer examination of the tender region showed neither swelling, nor redness, nor œdema; there was nothing but pain to guide us. But what more do we often get in joints in their early state of inflammation? and the earlier the diagnosis the better the patient's prospects; and especially in sacro-iliac disease, in which the outlook, if the cases are left "to nature," is hopeless in the extreme. I refer you to a paper by Makin, in the Clinical Society's Transactions for 1893, where, failing personal experience, you may see that of others carefully collected and commented on.

Now, the spot to seek for pain in early sacro-iliac disease is very definite: it is *not* posterior, between the flank bone and the spine over the posterior sacro-iliac ligaments; there may be pain there, and especially in more advanced cases, but at that point you are nearly, if not quite, two inches from the joint. The exact position of the joint (and the spot where it is nearest the surface) is to be found by drawing a line from the posterior inferior iliac spine to the crest of the ilium, three inches

(in adults) behind the anterior superior spine. Describe the outline of a pear, the stalk of which is represented by the posterior inferior spine, and the "eye," a spot two and a half inches up this line. You have now marked out the joint; and firm pressure over this area elicits pain at once—you jam the ilium against the sacrum. If there is anything wrong in the joint, firm pressure here will find it out; it did so in our patient, and I at once advised treatment as for any other joint, viz., its early erasion, or, perhaps, excision, it being clearly tubercular. I cannot now discuss why this diagnosis of tubercle was given; it must suffice to mention the other possible causes; but we excluded them. We thought successively of a pyæmic joint due to gonorrhœa; to general pyæmia (puerperal, if woman), and to one or other of the exanthems; of syphilitic disease; and lastly, of malignant disease. This last wonderfully resembles tubercle in this part; but generally the pain is excruciating and a tumour is sooner or later found, and it is mostly in patients past 35 years of age, but it has been seen in a nine-year-old child.

Now, although I must confine myself to our case, I must point out that tubercle of this joint, as in others, is a very chronic trouble, and that the suppuration complications it may cause, if it is not arrested early, are both peculiar and dangerous. Thus, pus having formed in this joint may come out posteriorly through the posterior sacro-iliac ligaments—about the least objectionable route for it—or anteriorly, forming an iliac abscess, pointing at Poupart's ligament, or it may descend the curve of the sacrum and open into the rectum or perinæum, or *viâ* the great sacro-sciatic notch it may travel with the great sciatic nerve, and appear below the gluteal fold behind the thigh, or, lastly, and not unfrequently, it may travel to the spine and set up a pachymeningitis; and this is more likely if the disease is complicated, as it is sometimes with Pott's disease, low down. But here there is a point worth notice. I do not remember a case ever beginning (that I could prove) in the iliac half of the joint, but either in the joint, or sacral portion of it. Lannelongue denies its commencement in the joint. I can only say, one case I operated on lately was, I believed, absolutely confined to the joint; but we can, I think, see a reason for tubercle favouring the sacral surface. It is the only one with an epiphysis, and the disease in origin becomes quite comparable to a tubercular epiphysitis anywhere else.

But I must pass to treatment. The joint can be thoroughly excised. I first did it on an advanced case in 1880, which you will find quoted by Erichsen; but as the case already was far advanced, the operation had not such opportunities as in this case, and in one other which lately came under my care. The method is as follows:—Reflect a flap of skin by a horse-shoe incision which widely embraces the area of the joint before given; the curve of the horse-shoe follows the edge of the ilium; its points—the hinge of the flap—are widely on either side of the most anterior point of the joint—the "eye" of the pear. Turning the flap upwards and forwards the glutæi are raised from the bone, and a large trephine hole made in the line before given, and touching the base of the posterior inferior iliac spine below. The disc of bone—which here is very thick—being removed, the joint is seen; and in this case tuberculous granulation tissue and pieces of exfoliated cartilage were removed. The ilium is now freely removed all over the joint area, and it then becomes possible to lift up the ilium from off the sacrum, so if the whole iliac surface has not been quite removed, the surfaces of the joint can be easily attacked with a sharp spoon.

At this stage we met with a very distinct surprise, for pus began to well up—a few drachms only—from below and from the front, and on following with the gouge, we discovered the commencement of a small subperitoneal abscess lying just over the front of the joint, close where the lumbo sacral cord comes down, and another, to reach which part of the great sacro-sciatic ligament had to be divided, forming a pouch by the great sciatic nerve.

Both were, of course, scraped out and thoroughly irrigated; the sacral epiphysis also scraped bare of cartilage, and every point around rendered as clean as possible, and the whole cavity now remaining was filled with iodoform and glycerine. The soft parts were returned to their place, sewn up without a drain, and the wound hermetically sealed. Primary union resulted, and the patient is to all appearances rapidly convalescent.

Although, of course, the time has not elapsed for any expression of opinion as to permanency of the cure, I may fairly predict it, by judging the case by the side of a very similar and early one on which the same operation was performed early last year. The patient is perfectly well, and walking about without any protective apparatus, though a Thomas's splint was worn,

as it will be in this case, for the first three months or so of being about.

To discuss the full value or the treatment of the various and interesting complications of sacro-iliac disease is not my intention now, as the case did not manifest them. But there is one point I would mention, if only as a warning. It is that of all positions in which, in a late case of the disease, sinuses are likely to be met with, the most likely is the space between the ilium and the sacral spinous processes. There the pus finds comparatively easy egress by perforating the posterior sacro-iliac ligaments; and through that same path I have tried, with others, satisfactorily to reach the focus of disease. I have no hesitation in saying that it is impossible to explore the joint by such a route; an appeal by any of you to the skeleton will directly convince you of this. And so I advise in the late, as well as in the early stage of the disease, attack the joint by the route I have described above, and then attend to sinuses or other complications that may be co-existent.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY
4, 19. Mitral regurgitation.
12. Mitral stenosis and regurgitation.
14, 18. Mitral stenosis.
15. Aortic and mitral regurgitation.
16. Aortic aneurysm. Aortic and mitral regurgitation.
17, 40, 41. Chlorosis.
22. Mitral regurgitation. Anæmia.
38. Mitral stenosis and regurgitation. Tricuspid regurgitation.

STEPHEN
1. Mitral regurgitation.
6. Mitral and tricuspid regurgitation. ? Aortic stenosis.
16. Ulcerative endocarditis.
29. Aortic stenosis and regurgitation.
36. Mitral stenosis. ? Tricuspid regurgitation.
40. Aortic stenosis and regurgitation. Mitral regurgitation.

PHILIP
2. Mitral regurgitation.
33. Mitral stenosis. Mitral and tricuspid regurgitation.

Nervous System.

MARY
6. Chorea.
20, 29. Hysteria.
24. Exophthalmic goître.
33. Melancholia.

STEPHEN
4. Fits. Headache. Cerebral syphilis.
12. Cerebral tumour. Optic atrophy.
38. Myelitis.
22, 36. Syphilitic myelitis.
28. Double facial and auditory paralysis. Cerebral syphilis.
29. Left hemiplegia.

Alimentary System and Abdomen.

MARY
11, ? 34, 43. Gastric ulcer.
14. Pelvic tumour.
37. Constipation.

STEPHEN
9. Tuberculous peritonitis.

PHILIP
14. Epistaxis. Alcoholism.
35. Ascites. Cirrhosis of liver. Peritonitis.

Typhoid Fever.

MARY
31, 39.

STEPHEN
25.

PHILIP
5, 7.

Genito-Urinary System.

MARY
3, 8. Diabetes mellitus.
23. Chronic tubal nephritis.
48. Tuberculous kidney.

STEPHEN
2, 18. Chronic tubal nephritis.
15, 17. Acute nephritis.
19. Diabetes mellitus.
28. Chronic interstitial nephritis. Uræmia. Albuminuric retinitis.

PHILIP
18. Chronic interstitial nephritis.

Respiratory System.

MARY
5, 9. Bronchitis.
27. Pleurisy.
28. Lobar pneumonia.

STEPHEN
4, 35. Phthisis.
7. Chronic bronchitis.
13. Empyema. Phthisis.
26. Pleuritic effusion.

PHILIP
1, 17, 27. Pleurisy.
4. Empyema.
20. Hæmoptysis. Phthisis.
24, 28. Bronchitis and emphysema.
26. Fibroid lung. Bronchitis.
37. Phthisis.

Miscellaneous.

MARY
2. Syphilitic ulceration of tongue.
13. Suppurating bursa. Mitral regurgitation.

STEPHEN
8. Arthritis. ? Syphilitic. ? Tuberculous.

Acute Rheumatism.

MARY
35.

Nocturne.

By an Enthusiastic Dresser "Taking-in."

In the stillness of the night,
When the patients are asleep,
And the dressers, pipes alight,
Vigil keep;
When the chilly snow-flakes falling, Clothe the statue all in white,
Lamps throw shadows quite appalling, In the dim religious light;
Then what subtle pleasure mine,
When the hours of midnight sound,
Eating peristaltic pine
By the pound.

As the night is growing late,
There are acclamations loud,
While the porter ope's the gate
To a crowd,
And the "gentlemen" and "ladies," Stout and thin, and short and tall,
Using language fit for Hades, Range them 'gainst the Surgery wall.
Oh! Delights of Diagnosis;
Spotting fracture – Colles, Pott—
Spongy aural exostosis
And what not!

Through the bitter wintry air,
With a muffled kind of tread,
Ghostly forms their burden bear
To his bed,
When there's nothing more exciting, Than the ward fire's fitful gleam,
And there's Liquor Morph. inviting Him to sleep—perchance to dream.
Oh! the charm of operating
While the Surgeons soundly snore,
And the clock is indicating
Half-past four.

C. M.

Case for Diagnosis.

We should be glad to receive some suggestions as to the diagnosis of this case. We shall publish them together with the "Diagnosis and Post-Mortem Appearances," sent in by Mr. Floyd, in our next issue.

Thos. J., æt. 22, shoemaker. Admitted November 27th for swelling of abdomen.

Previous history.—Was in Swansea Hospital nine months ago, suffering from anæmia, was in one month and was much better when discharged; had bronchitis about six years ago; has also had scarlet fever; does not remember any other illness. No history of syphilis or alcohol.

History of present illness.—Commenced three weeks before admission; abdomen began to swell and he passed less urine than usual; patient has been gradually getting weaker during the last month.

Family history.—Unimportant.

Condition on admission.—Skin yellowish; conjunctivæ icteric tinge. Anæmic. No œdema of ankles. Not very well nourished; evidently lost flesh lately.

Heart.—Patient has a distressed appearance, though there is no actual dyspnœa; apex beat on fifth space, just outside nipple line, rather weak area of cardiac dulness, increased more especially towards the right side and also upwards; loss of resonance in region of second left costal cartilage.

Auscultation.—A loud systolic murmur heard all over cardiac area, attaining its maximum in pulmonary region in first left space half-inch from sternum. The murmur is also loud in tricuspid area; murmur of blowing character and replacing first sound in these areas. In mitral area not so loud and ends more sharply; second pulmonic sound slightly accentuated.

Pulse.—Rather frequent, small, low tension, irregular. Examination of blood shows nothing abnormal.

Lungs.—Normal.

Abdomen.—Appetite fairly good; abdominal discomfort due to distension; no vomiting; bowels rather loose; stools dark coloured; abdomen distended symmetrically; umbilicus protruding; resonant in centre from about one inch below umbilicus upwards; dulness in both flanks; resonant in right flank when turned on left side; fluctuation obtainable; liver dulness commences two-and-a-half inches below nipple, and thought to extend to about two inches below ribs; no enlargement of spleen to be made out.

Urine.—Deficient in quantity; sp. gr. 1028; no albumin; not dark.

December 5th. Temperature rising. Complains of pain in right hypochondriac region; slight increase of urine under digitalis.

7th. Temperature 101·4. Abdomen rather more distended.

10th. Temperature 100. Abdomen more distended; great discomfort; pulse small, weak, irregular. Paracentesis. O. v. clear serous fluid drawn off.

18th. Loud systolic murmur attaining its maximum in first left space, three-quarters inch to left of sternum, where it is accompanied by marked thrill; very slight accentuation of pulmonary second sound. No *bruit de diable*. Murmur very loud in tricuspid area, but appears to be the same as heard in first left space. No pulsation in arteries or veins of neck; pulse small, low tension, regular.

Abdomen distended, symmetrical, hyper-resonant on right side and in centre. Absolute dulness on left flank. Dulness being gradually overlaid by a tympanitic note, which gets very marked at nipple line. Line of partial resonance just underneath ribs. On turning patient to right side the anterior three inches of dull area disappears, *i.e.*, there is now a tympanitic note, but no corresponding dull area in centre or right flank suggestive of dropping back of cause of dulness into the

deeper parts of the abdominal cavity. No solid tumour to be felt; no œdema of legs. Temperature 103·4 in evening, having been 98·2 same morning.

19th. Paracentesis—O. iv. clear serous fluid drawn off; face beginning to swell, especially under eyes; no redness, no defined margin; legs and ankles swollen and pit on pressure.

24th. Fluid has accumulated rapidly; hæmorrhage from left ear, nose, and mouth; liver dulness normal. Patient became worse, and died at 7 p.m.

During the last week of illness temperature remained high, ranging between 102—104; it was at its highest in the evening of each day; just before death temperature sank to 101·2.

The Defects of the L.D.S. Curriculum.

THE attention of the highest authorities can scarcely be too forcibly directed to the urgent need of considerable alterations in the Dental Curriculum and the L.D.S. examination, for students justly complain that no ordinary man can do the work required in the time allotted.

The dental student is supposed—within two hospital years—to dissect and to attend the same lectures as other medical students, in addition to lectures upon surgery, clinical surgery, and medicine; and in his intervals of leisure he is left to complete a very extensive special course of study and practice. The dental course includes a large number of special demonstrations and lectures of which, for instance, fifty are devoted to dental surgery and pathology, and a similar number to dental anatomy. The students could manage to attend these lectures of an evening, but they succumb to the additional imposition of two years' dental practice—which has, also, to be crowded into the same period, without the option of attending patients by night.

A second-year man at Guy's has to do 300 fillings, 150 of which must be gold, and the test filling at the L.D.S. examination requires about three hours at full speed. Many a filling done in hospital requires nearer six hours than three, even in skilled hands. These fillings do not represent more than half the practical work necessary, so it is clear that something must be neglected. The demonstrators in the dissecting-room ask us to allot certain hours of the week for dissections, but we are unable to draw up a time-table because the day is not long enough for the work that has to be done, so we are obliged to leave the individual student to exercise his judgment as to what he shall neglect.

The case is further complicated by the deplorable arrangements of the College of Surgeons in regard to the apprenticeship. Students are supposed to do three years' dental mechanics, and this should be finished before they enter hospital; but there is a simple way of evading the third year, as the authorities take no steps to ascertain whether the pupilage has been well or badly spent. The consequence is we have some students entering hospital whose apprenticeship has been nominal and who have spent two or three years of their youth in acquiring idle habits. To our lot it falls to teach these gentlemen the art of dental mechanics, or their failure at the L.D.S. examination reflects discredit on our School.

The best course would be to prevent students from entering hospital before they have passed the examination in dental mechanics. Then, they would come to us with skilled hands, and be more fit to learn the delicate manipulation of dental surgery.

The next important alteration needed is the extension of the hospital career to three years instead of two. At the present time there is only one examination, held at the end of two years, and candidates have to take up anatomy, physiology, surgery, and several dental subjects, to which are added practical examinations in dental surgery and dental mechanics. It is high time to add a third year, and to divide the examination into two parts. The first examination should be held at the end of two years, and the student would be examined in all his subjects excepting surgery, dental surgery, and practical dental surgery, which would be reserved for the final test at the end of the third year.

F. NEWLAND-PEDLEY.

The Scientific Diagnosis of Nervous Disease.

II.

"THE practice in these cases is more varied, and requires greater accuracy . . . wherefore it is a task to learn this accurately, so as not to commit small blunders either on the one side or the other, and in fact I would give great praise to the physician whose mistakes are small, for perfect accuracy is seldom to be seen, since many physicians seem to me to be in the same plight as bad pilots . . " HIPPOCRATES. *Treatise on Ancient Medicine*, § 9.

The writer is indebted to Dr. F. Taylor for permission to publish the preceding case, the report of which is founded on Mr. J. R. Steinhaeuser's careful notes. Neither of the above-mentioned gentlemen would wish, however, to be held responsible for any statement that follows. The points about the case, which any diagnosis should, if possible, explain, are the following:—

(1.) Five weeks' progressive onset, beginning with sensory and motor symptoms confined to right hand, succeeded by stiffness of right leg.

(2.) Peculiar gait. Inco-ordination of right arm and leg. Paresis of movements of right wrist and fingers.

(3.) Sensory impairment in palm and fingers of right hand, and to a less degree in sole of right foot.

(4.) Clonus; exceedingly brisk tendon-jerks in a four limbs. Very lively skin-reflexes.

(5.) Bladder and rectum normal.

(6.) Absence of trophisms and R.D.

(7.) Absence of any definite sign whatever of intracranial disease.

(8.) Absence of evidence of disease of the heart or vascular system.

(9.) Last, and least—and for localising purposes almost valueless—history of exposure to—

α. Syphilis.
β. Weather.
γ. Alcohol.

Now, in approaching the diagnosis of a nervous case, it is the practice of some to propound as the first problem for solution, *Is it shamming?* And as the second, *Is it functional?* The principle of this is totally wrong. No doubt much time and anxiety are saved by recognising functional or feigned disease early, but there is nothing on earth to prevent the subjects of organic and structural nervous diseases suffering as well from functional and nutritional forms of disease. *As a matter of fact, they frequently occur in combination together.* It is a matter of experience that in a suitable subject "hysterical symptoms" may be excited or intensified by other diseases not necessarily of the nervous system. Gowers gives as examples typhoid, tuberculosis, syphilis, arthritis, uterine disorder, injury, laryngitis, bronchitis, etc. "If hysterical symptoms may thus complicate general and local diseases, it is not surprising that they frequently accompany various diseases of the nervous system, functional and organic," *e.g.*, cerebral tumour, tubercular meningitis, multiple neuritis, chorea, diphtheritic paralysis, etc. Hear again what Gowers has to say elsewhere. "In the diagnosis of functional disorders, the *first* element is the exclusion of any sign of positive disease, and the *second* is the discovery either of some morbid state capable of giving rise to the functional derangement, or of associated symptoms unequivocally functional in character. The first of these is that of primary and paramount importance, which, alike in practice and reasoning, should precede the others." And again: "It must be remembered that there is no sharp line of demarcation between functional derangement and nutritional changes. As already mentioned, no functional state can exist without leaving behind it some corresponding change in the finer molecular nutrition of the strictures." Tetanus and hydrophobia are no longer described as functional diseases of the nervous system, but they are invariably evidenced by serious nutritional and functional nerve disorder. Much gross injustice would be avoided and many a reputation saved if the above rule were made absolute. Amongst many examples of its importance which have come under the writer's notice, the following is one of the best. In a competitive examination some years ago his duties required him to examine a most respectable young woman admitted for paraplegia. On requesting the patient to try to walk, she was dissolved in tears. "Come, come, sixty, don't be so silly," said the heroic emale attendant at her side. Examination showed the case to be clearly one of moderately advanced ataxic paraplegia—prognosis unfavourable. The poor thing, so long as she could put one foot in front of the other, had bravely struggled to gain her living as a nurse. For more than a year doctors had tormented her by telling her and her friends (not numerous) that "*she could walk if she chose*," and that it was *only* "hys." Treatment, asafœtida, etc. It would have been a very remarkable thing indeed for any woman (worthy of the name) finding herself becoming helpless from gradually increasing paraplegia, her livelihood gone, with the prospect of bedsores and incontinence of urine and fæces, death and autopsy (carefully gone into, of course, at the bedside), to say nothing of the contempt and unsympathy of students, sisters and nurses, as being a "hysterical" patient; nay, the wonder would have been, I think, if she had *not* become emotional under the circumstances. Joy and love depend upon the consciousness of the presence in others of ideas and feelings akin to our own; grief and hatred on the consciousness of their absence.

The transient nature of symptoms is far from disproving the organic nature of the disease. One of the best examples of disseminated sclerosis which has come under the writer's notice was in a man named Alfred Roberts, aged 23, in Stephen 17, under Dr. Taylor in June 1891. (The report of the case by Mr. Huntley, then ward-clerk, is alike a model of laborious exactitude and faultless caligraphy). In 1888 he was under Dr. Pavy for a month with "Aortic regurgitation, cerebral embolism, left hemiplegia." In 1891, besides severe heart disease, a bruit and thrill that could be heard and felt in almost any part of the body, he came in with nystagmus, slow speech, marked tremor, and incoordination of all four limbs, so that he was unable to walk across the ward, unable to feed himself, and any handwriting was not only illegible but impossible, for he could not hold a pen without dropping it. Two months later, after prolonged rest in bed, and arsenic, he went back to his work *practically well.* The tremors could only be elicited with much difficulty; he was able to walk about quite comfortably if not hurried; he could feed himself and write quite legibly. The speech was no longer characteristic, and nystagmus could not be obtained. The tendon-jerks remained lively, and the skin-reflexes (with the exception of the plantar) were still absent. So, too, if there is one disease more than another which is essentially structural and involves every cell, and fibre, and blood-vessel of the entire nervous hierarchy, it is *general paralysis*, yet everyone knows that *the* difficulty in diagnosing general paralysis depends upon the vague and transient nature of the earlier symptoms; and, again, the most marked cases may have complete remissions of all the symptoms *for months or years* (Mickle). Our proceedings must, therefore, be as follows:—

(1.) Search for (and if possible exclude) definite unequivocal evidence of organic disease.

(2.) If there is any single symptom which *may* be due to structural disease, localize the lesion as accurately as possible.

(3.) Determine its probable pathological nature.

(4.) Having made at all events an approximate regional and pathological diagnosis, compare the case in every particular with the described types of the disease. If it corresponds, well: but if not, either there is some flaw in our observations and reasoning, or it is a case of multiple lesions, or it is not a case of structural disease.

(5.) Exclude the existence of heart and vascular disease, diabetes, uterine disorder (not forgetting pregnancy), uræmia, plumbism, etc.

(6.) Having gone through all the preceding conscientiously, then (and not till then), search for evidence of hysteria or associated symptoms unequivocally functional in character, remembering that Dr. Buzzard has "watched for years the sequel of many such cases, which, long diagnosed as cases of hysteria, drifted into examples of disseminated sclerosis."

Taking the case under consideration, the symptoms which might well be due to organic disease are (1), (2), (3), and especially (4), increased tendon and skin reflexes.

In localizing (or attempting to localize) the lesion, we have the following structures to choose from:—

A. Muscles.
B. Peripheral nerves (including the nerve-endings in muscle which may be peculiarly affected, the motor-endings by curara, the afferent terminals by tabes).
C. Spinal structures.
   α. Anterior and posterior roots.
   β. Spinal cord.
   γ. Cauda equina.
D. Intracranial contents.

A. Diseases in which the lesion is in the MUSCLES, and is evidenced by—

α. Hypertrophy—as in *pseudo-hypertrophic paralysis* and *hereditary myotonia* (Thomsen's disease); or

β. Atrophy—as in *idiopathic muscular atrophy* (including again *pseudo-hypertrophic*), and perhaps *arthritic muscular atrophy* (this is said to be due to reflex influences from the affected joint acting on the affected muscles through the spinal cord. Division of the posterior roots prevents the muscular wasting. No motor neuritis or spinal lesions have so far been found).

Characteristics. Symptoms of peripheral, spinal, or cerebral disease are all absent. With the exception of arthritic atrophy (put here for convenience), the other diseases are all *hereditary myopathics*. The position of Thomsen's disease is still a little uncertain, as no examination of the central nervous system has yet been made. In some cases, the tendon-jerks have been increased, and polar changes to galvanism have been noticed. In all these cases, the order in which the muscles are affected probably depends on their order of development, and does not correspond to any "spinal type" (see later).

Thus, the muscles which most commonly hypertrophy in pseudo-hypertrophic are the following:

Deltoid.
Triceps.
Supra- and infra-spinati.
Serratus magnus.
Calves.
Quadriceps extensor
Glutei (*Beevor*).

The C_5 root spinal segment supplies the following muscles:—
Deltoid—
Upper half of pectoralis.
Biceps.
Supinator longus.

The C_6 root segment supplies:—
Triceps—
Latissimus dorsi.
Lower half of pectoralis.

These myopathies then *pick out* muscles here and there from all sorts of segments without relation to their spinal grouping [contrast with infantile paralysis and progressive muscular atrophy]. The case under consideration bore no resemblance to any of these.

AB. The *peroneal type of family amyotrophy* described by Tooth, at present seems to hold a doubtful position between lesions in muscle and lesions in nerve. It is thought to be due to a chronic degenerative neuritis, especially prone to attack the motor fibrils and particular muscles. Pains and anæsthesia, however, occur in some cases.

B. PERIPHERAL NERVES.—These are "mixed" nerves, and hence the symptoms are both sensory and motor. In the very earliest stage of *irritation* the symptoms are cramps, tingling, hyperæsthesia, increased skin and tendon reflexes. In the stages of *degeneration* the symptoms are paresis, anæsthesia, analgesia, athermia, and absent reflexes wherever the nerves forming any part of the reflex arcs are affected. The peripheral parts of the peripheral nerves are affected earliest and most. The inflamed nerves, where accessible, are tender (=nervi nervorum and intramuscular twigs). Trophisms may be present, such as amyotrophy, modified R.D. and changes in skin, hair or nails. Vaso-motor phenomena may occur. Purely spinal symptoms, such as bladder and rectum trouble, and really good bedsores practically never occur. Psychical disorder, as in alcoholic women, or squint or dysphagia, or tachycardia or phrenic paralysis after diphtheria, etc., may give a seemingly central aspect to the case. The symptoms are limited to certain nerves, and the muscles and skin supplied by them. The most characteristic symptom of all is the symmetrical foot-drop ("even if she vows she is a teetotaller, you may feel perfectly certain she is a d-r-unkard"). Besides the familiar types of neuritis due to alcohol and lead, we ought certainly to mention *Beri-beri*, *Laudrys' Paralysis* (see *Lancet*, December 22nd, 1894), *and Tabes*. In Laudry's "acute ascending paralysis" there is little or no sensory disorder, no bedsores, and no R.D. The poison may be supposed to have a preference for the peripheral motor fibrils

(compare curarism). M. Dejerine was the first to speak of *Nervo-tabes périphérique* and the degeneration of the afferent intramuscular twigs is probably the real primary lesion. In this case the poison (syphilis) has a preference for the sensory peripheral fibrils, as in the optic atrophy, which occurs in 15 per cent. of cases of tabes. One of the most masterly generalisations of modern times was made by Gowers, when he pointed out that all these peripheral nerve-degenerations were alike the result of microbic toxines, whether produced by the humble yeast-plant, or by the more celebrated organisms of the specific fevers, such as diphtheria, malarias, typhoid, influenza, scarlatina, or syphilis. (Plumbism is at present an exception.)

In favour of a peripheral lesion the case presented the following points :—

(1.) Numbness in hand, first symptom.

(2.) Combined sensory and motor symptoms.

(3.) Absence of purely spinal symptoms.

(4.) Paresis of right hand and fingers, combined with tendency of toes to catch.

Against it, and in favour of a central lesion, were :—

(1.) Inco-ordination of right arm and leg with extraordinary gait.

(2.) Persistently exaggerated tendon-jerks, clonus, and skin-reflexes. A. J. S.

Notes from the Dispensary.

Acid Salicylic.

During the last two years a considerable amount of discussion has taken place respecting the impurities present in the Artificial Salicylic Acid prepared by passing Carbonic Acid into a mixture of Carbolic Acid and Caustic Soda at a high temperature, and decomposing the Salicylate of Sodium with an acid, and subsequent purification.

This Artificial Salicylic Acid is liable to two forms of impurity—(1.) Isomers of Salicylic Acid, which are formed if the acid is overheated during the process of manufacture. This impurity is very rare, and need hardly be taken into account. (2.) Homologues of Salicylic Acid (Cresotates), which arise from the presence of Cresol in the Phenol, from which the acid is made. There are three Isomeric Cresols—Ortho, Para and Meta—giving rise to corresponding acids—Ortho, Para and Meta-cresotic Acids. These acids very much resemble Salicylic Acid, but vary in their melting-point and physiological action.

It has been shown that Meta-cresotic Acid is practically devoid of physiological action, but that Ortho-cresotic Acid is unquestionably poisonous. Considerable doubt is still attached to the physiological action of Para-cresotic Acid. Several German physicians, and also one or two in this country, have given large doses of Para-cresotate of Sodium with success in many diseases, and find it less poisonous than Salicylic Acid itself. Dr. Charteris, of Glasgow, to whose investigations we owe the so-called "Salicylic Acid, Physiologically Pure," found that the lethal dose of Para-cresotic Acid, when injected into the circulation of rabbits, per kilo of body weight, was very much less than Salicylic Acid, and particularly so when given in combination with the latter.

Formerly, Artificial Salicylic Acid was very impure, the foreign elements being principally Ortho and Meta-cresotic Acids. In the Physiologically Pure Salicylic Acid of the present day the only likely impurity is a small quantity of the Para-cresotic Acid. It is found impossible to produce fine large crystals when this is present in fairly large quantity (5 per cent.), but 2 per cent. of the impurity does not materially interfere with crystallisation.

The most definite test of the purity of Salicylic Acid is the melting-point. The pure acid melts sharply at 156·85° C. and Para-cresotic Acid at 151° C. A reduction of 1° C. corresponds roughly to 1 per cent. of impurity. The melting-point given in the British Pharmacopœia of Salicylic Acid indicates a product containing about 2 per cent. of Para-cresotic Acid.

The following figures of the result of an examination of the Salicylic Acid Physiologically Pure, used in the Dispensary, will show what a remarkably pure acid can now be obtained commercially.

The Sodium Salicylate was treated with HCl., the acid collected washed with water until washings ceased to give a precipitate with Ag. NO_3, acidulated with HNO_3, then crystallised. The melting-point of this was carefully taken, and found to be 155·5° C. This would indicate about 1/10 per cent. of impurity.

It was formerly said that the Natural Acid is preferable to the Artificial for internal use. This statement at that time, no doubt, was true, but it is a very open question whether it will apply to the physiologically pure acid as now used.

The Period of Death recognised by means of the Cadaveric Insects.

M. Mégnin has recently communicated to the Académie de Médecine at Paris a very interesting account of the various insects which are found upon dead bodies, and the various periods when they occur. He has also published a work upon the same subject, "La Faune des Cadavres," which treats of the application of entymology to legal medicine. The subject is altogether a new one, and evidently, from its importance, the up-to-date text-book of medical jurisprudence will have to include a treatise upon entymology. It appears that dead bodies exposed to the air are successively invaded by insects according to the modifications produced by putrefaction. M. Mégnin has pointed out eight different kinds of insects which occur always in the same order from death to the complete destruction of the dead body. The following is the list :—

(1.) Flies of the species Curtonevra and Callephora. These occur upon flesh relatively fresh.

(2.) Lucilia and Sarcophaga, which appear three or six days after death.

(3.) Coleoptera of the species Dermestes and Lepidopteres and Anglossa. Three or four months after death. These flies are attracted by the decomposing fat of the dead body.

(4.) Flies of the species Piophila and Anthomigra and Coleoptera of the species Necrolua, which are attracted by the putrid fermentations known as the caseous. These flies are of the same species as those which occur upon cheese. These insects appear eight months after death.

(5.) Ophira, Phora and Tyreophora, which appear a year after death, if the parts are reduced to a black liquid matter.

(6.) Coleoptera of the species Silpha, Hister and Saprimis, which finish up by absorbing the liquid matters. This work continues up to eighteen months after death.

(7.) Coleoptera and Lepidoptera, which eat up the dry tissues, skin, tendons, and other parts which have escaped putrefaction. These insects thus amuse themselves during the third year.

(8.) The last group, which live upon the mould or débris which the others have left, are Coleoptera of the species Tenebris and Ptinns. They are found upon dead bodies up to four years. It must be specially noted that M. Mégnin's observations apply only to dead bodies putrefying in the open air. The knowledge of the insects found upon dead bodies decomposing in the soil has yet to come. H. COLLIER.

The Smoking Concert.

THE Smoking Concert held on Saturday the 9th inst., under the direction of Mr. H. M. Stewart, who occupied the chair, proved a very enjoyable affair. There was a good audience, but the smoking-room was at no time inconveniently crowded. The proceedings began with a pianoforte solo by Mr. Hardenberg, who also performed the duties of accompanist with his customary skill throughout the evening. Mr. R. B. Shipley followed with "Slattery's Mounted Fix," and later gave "Ho! Jolly Jenkins" in good style. Mr. Miller, who is a valuable addition to the ranks of the Hospital comedians, told some amusing anecdotes, some of which—if "chestnuts"—were none the less acceptable, and introduced some local colouring in "Her Golden Hair was Hanging down Her Back," which brought down the house. "The Mother and the Child were There" was dramatically given in response to an encore. Mr. Hicks pleased with that charming song of Lassen's, "All Souls Day," and in the second part was heard to more advantage in the plantation song, "Honey, oh Honey!" Mr. Fortescue-Brickdale's violin solos, "Gavotte" (Maurice Lee) and "Selections from Tannhauser," added to the enjoyment of the audience; while Mr. George Aspinall's singing of "A Spring Song" "Marie" (encore) and "The Vale of Llanherne" was a veritable treat. We are glad to hear that he has kindly offered his services on a future occasion. Mr. Allport has never been in finer fettle his energetic treatment of "I Can't Change It," given in his most humorous vein, was one of the best items of the programme, and his admirers would doubtless have listened with real delight to more than "They Hauled Me Back Again." Mr. Morley met with a flattering reception in "The Press-Gang," to which "The Yeoman's Wedding" followed in response to a vociferous encore. "Three Merry Men" was Mr. Morley's contribution in the second part of the programme. Mr. Michael, suffering from "a throat," sang "All through a Dear Little Lady" with great spirit. Mr. R. B. Ransford was heard to advantage in "Blow high, Blow low," and in "Hybrias the Cretan," which was well given, after the interval. Mr. Coulson sang with his usual vigour "When the Moon is Shining Brightly." And yet another favourite—Mr. Lulham—gave the very amusing sketch, "Bond Street." Mr. Stewart is to be congratulated on the success which attended his efforts in the arrangement of a concert which certainly proved one of the best we have attended.

The next smoking concert, which we understand will be arranged and conducted under the direction of Mr. R. H. Fagge, is announced for Saturday, March 11th.

The Guy's Niggers at Bletchingley.

CONCERT.—A large and appreciative audience assembled at the Board School on Monday evening on the occasion of the concert promoted by Dr. Oldman, in aid of the funds of the Streets' Lighting Committee. Dr. Oldman was fortunate in being able to secure the services of several gentlemen from Guy's Hospital, who carried out a long programme to the delight of everyone present.

Part I. opened with a pianoforte solo by Mr. E. F. Hardenberg and was followed by songs by Messrs. W. E. Robinson, Scott-Turner, and H. T. Hicks, and a recitation by Mr. H. J. Spon. The whole were enthusiastically applauded, and encores were frequent. An interval ensued, during which Miss Dora Howard gave a violin solo, which fairly carried away the audience, and in response to an undeniable encore gave another selection, both pieces being executed with consummate skill and precision. Part II. consisted of nigger "business" by the "Dis-Guysed" Minstrels, and opened with a banjo duet by Messrs. "Phlatfoot" and "Phuniphase." This was followed by the "Alabama Coon" (Massa Phuniphase), "I'm off to Charlestown" (Massa Bones), "The Oompah" (Massa Phlatfoot), "Macnamara's band" (Massa Tambo), duet, "I'm in love with the man in the moon" (Massa Snowball and Massa Jim Jams); song, "Razors in de air" (Massa Bones); plantation song, "Far away over dere" (Massa Johnson); "Honey, oh" (Massa Snowball), "Looking for a coon like me" (Massa Phuniphase), "Rumpti Tumti" (Massa Tambo), "Tin gee-gee" (Massa Phlatfoot), and "Good-night" (by the Troupe). The songs, etc., were freely interspersed with nigger "business" of the most approved type, the whole performance keeping the audience in continuous laughter till 10.30. We hope the financial result will be equally satisfactory. —From *The Surrey Mirror*.

Passim.

The Debating Society meets to-night in the Smoking-room, when Mr. Hamblin Smith will propose—"That in the opinion of this House the tendencies of modern journalism are deleterious to the common weal." Mr. C. P. Higgins will lead the opposition. The chair will be taken at 7.30 p.m.

The Gymnastic, Fencing and Boxing Competitions, as announced in our last issue, will take place on Monday and Tuesday evening next, for prizes kindly presented by the President. On the following Thursday evening (the 28th inst.) an Assault-at-Arms—to which ladies are specially invited—will be held in the Gymnasium. After the distribution of prizes by Dr. Pavy, who has kindly consented to preside, refreshments will be served in the Dining-hall. We understand that the programme will include horizontal and parallel bar exercises, etc., fencing, sword and bayonet, rapier and handkerchief, and other attractions. Admission will be by ticket (price one shilling, to admit a gentleman and a lady, or two ladies), which may be obtained from the Hon. Secretary, Mr. Duncan, or from any of the Committee.

The Resident's Annual Dance was held on Wednesday evening last in the Court-room, and, as usual, was pronounced on all sides an immense success. Among those present were Dr. and Mrs. Pye-Smith, Mr. and Mrs. Howse, Mr. Davies-Colley, Dr. and Mrs. Galabin, Dr. Horrocks, Dr. and Mrs. Shaw, Mr. and Mrs. Symonds, Mr. and Mrs. Brailey, Mr. Lane, Dr. and Mrs. Stevenson and Dr. Bryant. Mrs. Pye-Smith and Mrs. Howse were kind enough to act as hostesses, and to receive the guests, who numbered about 130. The music was excellent and the floral decorations and general arrangements perfect, and showed the great care and taste that had been expended on them by Mr. Stewart—who was indefatigable in his exertions as M.C.—and by his assistants, Messrs. Slater and Fagge. Our thanks are due to the Treasurer for so kindly placing his magnificent suite of rooms at the disposal of the guests, and to the stewards, to whose untiring endeavours the success of the evening was largely due.

We are glad to hear that a list of subscriptions to a testimonial for Parsons, who vacates his office at the end of March, has been opened. The list lies in the Library, and the Librarian will acknowledge through the medium of our columns all country contributions.

We are informed that there are two vacancies on the Photographic Committee, and that anyone desirous of becoming a member of that Committee should send in a letter of application to one of the Secretaries of the Physical Society on or before February the 28th.

Announcement is made to intending competitors of the following Prize Examinations to be held at the end of the Winter Session:—Examination for the Arthur Durham Prize for Dissection will be held on Wednesday, March 13th; the Michael Harris Prize in Anatomy on Monday, March 18th; the Beaney Prize in Pathology on Monday, March 18th; the Dental Prizes for First and Second Year's Students from March 19th to 22nd inclusive. Further information may be obtained in the Green and Brown Books, or at the Medical School Office.

At the time of going to press we hear that the Surrey Association Cup Tie against Ewell will not be played to-day. The Ewell ground is very hard at present.

Weather permitting, Guy's will meet St. Mary's in the first round of the Inter-Hospital Rugby Challenge Cup Competition on Tuesday next, on the Richmond Athletic Ground.

We are requested by the Hon. Secretary of the Guy's Hospital Christian Union to announce that a Lecture, to which the Nursing Staff is invited to be present by permission of the Matron, will be given by Herbert Lankester, Esq., M.D., entitled "The Work of a Medical Missionary" (with limelight illustrations), in the Court-room, by kind permission of the Treasurer, on Thursday next, February 28th. Tea and coffee will be served at 4.10 p.m., and the chair will be taken at 4.30 by Dr. T. Stevenson. We have no doubt that Dr. Lankester's lecture will be very interesting, and we hope there will be a full audience.

Appointments.

MARCH, 1895.

Clerks to Anæsthetists.—Messrs. H. T. S. Bell, H. A. Hinds, G. B. Muriel, A. S. J. Pearse, E. T. Shorland, C. B. Statham.

Externs.—Messrs. P. N. Vellacott, F. J. H. Cann, B. F. Pendred, H. R. T. Fort, T. Davies, C. E. S. Watson.

Dental Appointments.

MARCH, 1895.

Dressers in the Ordinary Extraction Room.—Messrs. E. D. Bascombe, E. Coltman, H. C. Cowles, T. D. E. Goodman, L. S. Hounsell, S. J. Evans.

Pass List.

University of London, January, 1895.

INTERMEDIATE EXAMINATION IN MEDICINE.
ENTIRE EXAMINATION.

SECOND DIVISION.

Evans, Evan
Fitz-Hugh, R. T.
Hodgson, C. R.
Mayston, R. W.
Moore, J.
Starling, H. J.
Wernet, A. J.

EXCLUDING PHYSIOLOGY.
SECOND DIVISION.

East, W. N.
Hall, E. S.
Moore, P. W.
Smith, D. L.

PRELIMINARY SCIENTIFIC (M.B.) EXAMINATION.

CHEMISTRY AND EXPERIMENTAL PHYSICS ONLY.

Foster, H. B.
Morgan, D. L.
Moss, B. W.

BIOLOGY ONLY.

Miller, E. A.
Ormond, S. J.
Ransford, A. C.

Final Conjoint Examination, January, 1895.

MEDICINE, SURGERY AND MIDWIFERY.

Bryant, C. H.
Handley, W. S.
Thomas, T. M.

MEDICINE AND SURGERY.

*Ensor, C. A.

MEDICINE AND MIDWIFERY.

*Constable, J. C.
*Every-Clayton, L. E. V.
Pakes, W. C. C.
*Pern, H.

SURGERY AND MIDWIFERY.

Bensted, L.
Jones, M. P.

MEDICINE ONLY.

*Burrell, L. C.
*Collier, H. W.
*Greenway, C. M.
*Hinds, H. A.
*Horton, J. H.
*Kearney, C. J.
Maxwell, E. J.
Moffat, H. A.
Moorshead, C. W.
Richmond, B. A.
Shorland, E. T.

SURGERY ONLY.

Alexander, A.
Beadnell, C. M.
Bird, J. W.
Byford, W. F.
Chapman, A. V.
Coleman, J. J.
*Evans, E. G.
*Fry, A. C.
*Hayes, R. H.
*Henderson, R.
Pendred, B. F.
Pitt, W. C.
*Reeves, A.
*Robson, T. S.
*Salter, A.
Thomas, D. W.
Wise, H. M.
*Zumbado, F.

MIDWIFERY ONLY.

Bourne, H. J. F.
Carden, W. A.
Coleman, E.
Davies, W. L. B.
Gocher, G.
Philipps, A. E.
Roberts, E. S.
Serjeant, R.
Sweetlove, J. W.
Statham, C. B.
Tresidder, M. E.
*Vallance, H.
Wallis, S. S.

* Denotes completion of Examination.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The "Dis-Guysed" Minstrels.

SIR,—With your permission, I should like to express, through the medium of your columns, the gratitude of the people of this village for the very pleasing and enjoyable entertainment, which the Guy's "Dis-Guysed" Minstrels were so generous as to provide for them on Monday evening last. It was a great success, and the financial results (£10 13s.) were larger than those usually obtained on similar occasions, which more than justify the eulogia previously expressed by you, sir, upon their performances individually and collectively. Their ready response to my invitation to assist an old Guy's man maintain the traditions of the Hospital, and fill me with gratitude which I fear I have only imperfectly expressed, but which I shall always feel. Apologising for trespassing upon your valuable space.—I am, Sir, yours, etc.,

Bletchingley. CHARLES E. OLDMAN.

Notice.

The attention of Dental Students is called to the following resolutions of the Dental Committee, which will come into force from the date of this notice:—

1. "That every Student borrowing instruments or impression-trays, the property of the Hospital, in charge of the Sister, shall sign for the same in a book kept by the Sister, and pay a deposit of 2s. until their return, in good condition. The borrower to be responsible for the instruments until returned to the Sister."

2. "That the re-fixing of crowns be marked as for plastics."

3. "That it is the duty of the Assistant Dental House-Surgeon in the Conservation-room to examine and initial all dental charts before dressers are authorised to commence operation."

February 21st, 1895. L. E. SHAW, *Dean.*

From the Gazette's Special Pathologist.

ALL specimens — particularly those of solid tissues— should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate.*

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

S. W. MACI., S. PETHERTON.—The main portion of the tumour consists of loose connective tissue, infiltrated with blood and permeated by dilated thin-walled capillaries, as in a nævus. The epithelium covering the tumour is somewhat warty. Apparently not malignant.

B. J., LEIGH.—The material contains, in addition to mucus and much shed epithelium, fragments of tissue which have the characters of papillomata, derived from the surface of a new growth. They are covered with elongated cells, the outlines of which are obscured by the action of the preservative fluid.

R. G. H., RAMSGATE.—Reaction acid: sp. gr. 1019. Blood and sugar absent. Albumin, considerable amount. A large number of casts are present and there can be no doubt of the existence of kidney mischief.

E. R. R., DULWICH VILLAGE.—No tubercle bacilli could be found.

W., WOOLWICH.—Culture shows a diffuse yellowish growth, rapidly tending to produce liquefaction. Microscopic examination proves the presence of quantities of a large bacillus, arranged in chains, and streptococci, but no bacillus diphtheriæ.

S. W., MIDDLESBOROUGH.—Tubercle bacilli are present in fairly large numbers.

J. R. A., SHERBORNE.—Culture shows a few scattered colonies not characteristic of diphtheria. Microscopic examination proves these to consist mainly of streptococci; no bacillus diphtheriæ observed.

R. G. H., RAMSGATE.—Acid, 1025; blood and sugar absent. Albumin, large amount (probably rather more than in previous specimen). Casts are still plentiful, mainly of the hyaline variety. They seem, however, to have decreased somewhat since the last specimen. There is little or no pus in the residue.

R. B. M., SWAFFHAM.—Sections made from the wall of the cavity in the testis showed merely the results of inflammation. There were no signs of tubercle or malignant disease.

H. R., FORDINGBRIDGE.—The growth is a soft round-celled sarcoma, exhibiting an imperfectly alveolated structure in several parts.

ALBANIAN.—The growth is a squamous-celled epithelioma invading deeply the subcutaneous tissue.

J. A. S., DERBY.—The growth is a scirrhus carcinoma consisting of dense fibrous tissue traversed by narrow lines of epithelial cells. Remnants of gland tissue are seen at the margin of the growth.

H. L. E. W., SALISBURY.—(1.) The growth from the gum shows a warty condition of the mucous membrane and diffuse inflammatory changes in the subjacent tissue. There are no signs of malignancy. (2.) The growth from the front of the trachea is composed of fibrous tissue in which are embedded lobules of thyroid glandular substance. In some parts this substance is undergoing cystic degeneration.

H. H., BLISWORTH.—The growth is a squamous-celled epithelioma of the papillary type. There are corpora amylacea in the subjacent muscular tissue of the cervix.

J. McC., ST. GEORGE'S, SHROPSHIRE.—No tubercle bacilli could be found. PATHOLOGIST.

Guy's Hospital Dental Department.

PRACTICE DURING JANUARY, 1895.

Gold Fillings	350
Amalgam ,, ...	566
Osteo ,, ...	
Perm. G.P., ...	
Regulations	3
Artificial Crowns	57
Dentures	14
Dead Teeth	168
Scalings	35
Attendance for Extraction under Anæsthetics ...	956
,, ,, without ,, ...	574
Total	2723

On Sleep, Insomnia, and its Treatment.

A paper read before the Pupils' Physical Society, on February 16th, 1895, by Mr. C. H. FAGGE.

MR. CHAIRMAN, PRESIDENTS, AND GENTLEMEN,—It is my misfortune to be unable to-night, after the manner of some of my predecessors in former years, to place the onus of the calamity you labour under upon the worthy backs of those Presidents who were once responsible for the choice of him who should address you. Now, and I say this partly as a hint to future aspirants, the situation is entirely due to the temerity of the individual—for such temerity, in my own case, I render due and very necessary apologies.

The choice of my subject seems to me to call for but slight comment, for we, as practitioners in embryo, should ever bear in mind the words of one from whom, though in his grave, we can still learn much: "Rest is the necessary antecedent to repair and growth." Therefore I shall endeavour to bring to your notice the most perfect form of rest—sleep: and as, in our career, the study of physiology precedes pathology, the discussion of the condition of normal sleep will precede that of insomnia, followed by a brief outline of treatment—the warfare against effects being thus better carried on by a true physiological knowledge of cause. Such highly interesting but theoretical states as catalepsy, somnambulism and hypnotism, so much enlarge the field of discussion and border on other sciences, that I have been forced to entirely omit them.

The literature of sleep probably dates from almost prehistoric ages, for in Homer we read that "gentle slumber on his eyelids fell, That deep sweet sleep which death resembles well"; the same idea being in the mind of Hippocrates, who recognized the extreme latency of the animal functions; yet this sophist and Galen and Synesius later were led away into the consideration of the spiritual import of dreams. Ferrerius,* in the sixteenth century, regarded sleep as an important index to the physical condition of the individual.

We cannot improve upon Haller's definition that "sleep is an indisposition to exercise of sense and voluntary motion with an inclination to rest, in all organs while they remain healthy and entire." He follows with the statement that "cardiac motion with distribution and circulation of all the other humours is regularly continued. The same author opposed the general opinion that the centre or seat was in the ventricles of the brain, as sleep was possible in animals without these cavities, and also as the idea is not consistent with the ample bounds of sleep.

What sleep actually is, mentally, we do not yet know, but the conditions of the various bodily systems in this state are:—

(1.) The expression of the face is passive.

(2.) The eyelids are closed—a state obtaining throughout the animal kingdom, except in hares.

(3.) The eyes are rolled upwards and inwards, and the pupils contracted. This was noticed by the early physiologists as a true test in malingerers, and Mayo remarks on the rapidity of the change in waking. Foster has observed that dilatation follows the stimulation of any sensory surface during sleep, and regards this as a proof that sleep is not merely a loss of afferent impulses, for then, the retina being quiescent, the pupils should dilate; probably, he thinks, it is due to continuous action of the midbrain. Rosenbach, however, seems to regard the contraction as reflex.

Dr. Wilks has pointed out in some patients a condition of general calm similar to the hypnotic state in which the pupils dilate, and afterwards, as each is aroused, quickly contract. From such he infers that "somnambulism is not true sleep, for the somnambulist can walk in dangerous places without falling, showing that the eyes are *still impressionable and capable of guiding the body*, so that to the doctor who said of Lady Macbeth: "Lo, here she comes, yet she is fast asleep, although her eyes are open": the gentlewoman answered wrongly with: "Ay, but their sense is shut."

(4.) The next noticeable condition is one of lowered temperature; this is slight, and only of interest in connection with the similar process in hibernation, to be briefly dealt with later.

Sir Dyce Duckworth states the fall to be greatest about 3 a.m., when it may be even 1 degrees below normal, in his opinion denoting the direct nervous influence on heat production.

(5.) Sir Henry Holland was the first to point out the augmentation of the perspiration during sleep, which he opines is intimately interwoven with the causation of sleep, possibly of direct vasomotor origin.

(6.) If position allows of the relaxation of the muscles of the limbs, they take up the position of semiflexion; this is said to be the most convenient position of rest and to be due to the general shortness of the flexor tendons, which dates from the processes of growth in the earliest ages, when the continued flexion of the limbs was greater than at any subsequent period; as regards the other muscles, the sphincters, and those which may be called "vital," continue to act, but respiration, though deeper, diminishes in frequency. Mosso has pointed out here, a want of correspondence between the thoracic and abdominal types, for when the thorax is expiring, the abdomen is fixed, and when thoracic inspiration begins the abdomen expires, but during continuance of thoracic inspiration elevation of the abdomen also occurs—corresponding with inspiration—the cause being that the diaphragm—most active during the waking hours—is inactive and almost paralysed during sleep. On waking, the normal relations are speedily re-established.

(7.) A most prominent place must be given to the alteration of the respiratory quotient during sleep, for, as shown by the experiments of Pettenkoffer and Voit, more oxygen is taken in at night than is discharged as

* . . . . "Ut cum dormientes nos domire putamus, jacentes *jacere, ægrotantes ægrotare. Huius generis erat et illud P. Cornelii* Rufi qui consul cum M. Curio fuit. Dormiens enim visum oculare amisit, cum id sibi accidere somniaret."

carbonic acid, the opposite being the rule by day; thus in the marmot the respiratory quotient is at night reduced from ·8 to ·5 (Waller). A similar state of things in man will partly account for the decrease in heat production—which Waller shows to be sixty kilocalories per hour less at night than when the person is awake and at rest.

(8.) As regards the state of the alimentary canal, the secretion of all the juices is diminished, and so digestion decreases—this relation I do not understand, but it perhaps accounts for the evil effects of a long sleep after meals, though no doubt a nap is distinctly beneficial: again, peristalsis and progression of fæces are lessened; while the sphincters remain active: the sense of hunger is also quenched.

(9.) The excitability of the cerebral cells is diminished—being inseparable from the condition of sleep, of which I hope to show it to be the prime factor—but here it is needless to deal further with nervous phenomena than to note the condition of the reflexes—these used to be regarded as simply those of a decapitated animal, but of late Rosenbach has shown that they vary with the depth of sleep, of which he says "we have no exact standard: rather can we by the reflexes estimate the depth of sleep. In sleepy children the reflex excitability is increased, but in early light sleep there is a weakening of all reflexes; in the second and deeper stage abdominal, cremasteric and tendon reflexes are abolished, while in the deepest stage tickling the sole of the foot will liberate the reflex."

It is worth notice here that he regards the activity of the sphincters as due to augmented cerebral activity, and not reflex—an opinion not well suited to the more recent ideas of the cerebral condition, for Rosenbach says: "if sleep is merely a cerebral paresis, we ought to get enhancement of spinal reflexes as in decapitated animals, but these appear to weaken as sleep deepens—hence the supposition that not only is there no temporary emancipation of the cord, but even active restraint of reflex activities."

As I have said previously, such ideas are ill suited to experimental proofs; to me it appears more probable that the temporary emancipation of the cord, which must occur, is more than counterbalanced by the diminution in the blood-supply, an alteration which it seems quite necessary to allow on anatomical grounds alone, when we remember the intimate connection of the vascular systems of the brain and cord.

(10.) I have shown the almost general diminution in secretions, and now I come to the urine, which Foster finds slightly decreased, with an almost corresponding fall in urea. The chief interest, however, is attached to the other solid constituents. Mendel found nocturnal urine richer in phosphoric acid than that excreted during the day, in connection with which may be mentioned the conclusions of Wood that alkaline phosphates increase at the expense of the earthy salts during mental activity. Bouchard, in his work on uræmia, discovered the toxicity of human urine when injected into the veins of rabbits, and found that this power varied at different times—thus, urine collected after sleep or after hard work in the open air was less toxic than under opposite conditions; the toxic alkaloids are numerous, some convulsive, others soporific or coma-producing; they are derived from the food, especially from potassium salts, from intestinal decomposition and from tissue degeneration. The mixture of urines collected during the sleeping and waking hours is less toxic than either constituent, the night urine being convulsive, the day coma-producing.

(11.) I have purposely left till last the consideration of the circulation. We find that the heart beats more slowly and probably not more forcibly during sleep, although Boerhaave wrote: "*In somno motus augetur cordis.*"

Mosso, considering as proved the law that the emotion produced in the passage from profound rest to cerebral activity is always accompanied by a modification of the pulse, has shown with the plethysmograph that in going to sleep a dilatation and relaxation of the vessels of the forearm occurs, with contraction on waking, and from experiments on natural and induced sleep (due to chloral) he obtained a general result that in waking there is an increase in the size of the pulse tracings. With direct regard to sleep, he found that every excitation from without causes a contraction of the vessels of the forearm and increase of blood-pressure with a consequent greater flow to the brain, and during sleep, when heart movements are slowed, external stimuli, insufficient to arouse the patient, may constrict the vessels, without consciousness of such affection.

The key of the intra-cranial circulation is found in Hughlings Jackson's observations with the ophthalmoscope on six persons showing that during sleep the retina was paler than in the waking state, the arteries were rather smaller than normal, while, as a rule, the veins were engorged,; in every case the capillary circulation was diminished: this was later confirmed by Prof. Gairdner. Now, the contraction of the retinal arteries—their origin being remembered—taken in conjunction with the fact that pressure on both carotids causes a condition of stupor, closely analogous to sleep (of which the Borough garrotting case afforded us an excellent example) is quite sufficient evidence to entirely refute the assertions of some physiologists—amongst whom was Marshall Hall—that in sleep the brain was in a hyperæmic state. Again, the venous engorgement of the retina is surely a strong point in favour of the intra-cranial veins being in the same state, and we may be proud to know that Mr. Durham had given proof of this condition on true physiological grounds in the Reports for 1860, when he showed venous engorgement of the pia mater during sleep after chloroform narcosis, with gradual subsidence as the dog came round. Dr. Kennedy observed the same condition in a man in whom the pia mater was exposed by the trephine after an injury.

Having established the facts of arterial constriction and engorgement of the pia matral veins, we must now

discuss the share these factors have in the production of normal sleep, and how far other elements enter into it.

In dealing with what I may roughly call primary or exciting causes, the idea of sleep being the result of intellectual activity is almost precluded by the mere fact of the accompanying cerebral anæmia, and further support is supplied by the rarety of successful attempts to produce sleep by this method. That the state of anæmia is *per se* the prime cause is negatived by the following facts:—(i.) A patient dying from hæmorrhage faints but does not fall asleep. (ii.) Syncope is not sleep. (iii.) Chlorosis, with its attendant blood poverty, is often accompanied by wakefulness. (iv.) A refreshing nap does not revive the languor of well marked anæmia.

Sommer's theory was the outcome of the researches of Pettenkoffer and Voit, which have been referred to, for, considering that during sleep oxygen is gradually stored up in the body, he observes that at some period it must be in such excess as to materially accelerate the metamorphosis of nervous and other tissues, and so wakening comes about: *pari passu*, the elimination of O, and accumulation of CO_2—formed by the oxidation of metabolic productions, creatinine and lactic acid — will account for the exhaustion of nerve tissue accompanying the desire for sleep. Pflüger has amplified this view with the supposition that the waking state is caused by the molecular vibrations occurring in the chemical combination of C and O. Preyer viewed the process as one of toxicity rather than exhaustion, due, he considered, to the acid products of protoplasmic activity, of which lactic acid is regarded by him as the chief; he is further of opinion that this substance has, when given internally, a direct hypnotic action. Although Foster allows such factors in the causation of muscular weariness, yet he truly points out that a larger and not smaller supply of blood would be necessary to wash away such products from the brain, and enquires on such a supposition what hope we could have of waking. However, we must recollect Bouchard's observations here, and remember, as Christison has shown, that diminished elimination of urinary products may lead either to coma or to deep and prolonged sleep.

Meynert, and even later, Büchner, have written supporting Preyer's views, and regard the accumulated waste products as exciting a dyspnœtic phase of nutrition by interfering with the "respiratory" processes of the nerve cells. The chief objection to the view of O. starvation is, as Foster has pointed out, the necessity for the bye-play of some inhibitory mechanism, by which the respiratory centre is not roused to marked activity by this want, though working with sufficient energy to allow a gradual restoration of oxygen with final awakening.

As to the maintaining causes, we are face to face with a most vexed question—one upon which many eminent physiologists have differed — viz., whether the volume of the cranial contents is a constant or not? That it was unchangeable was first stated by Munro Sec., and has of late found its champion in Dr. Cappie, of Edinburgh, who—having established the vascular relations given above, and concluding that the total volume of the brain, blood, and cerebro-spinal fluid in the cranium, cannot alter—neglects the latter as having no share in the process, disbelieving the truth of the histological researches of Majendie and the philosophy of John Hilton, and so argues that the volume of the brain varies invariably as the blood in the cranium —slight variations only of pressure being necessary to change the cerebral state from activity to rest. I do not propose to trouble you with the many experiments of Kellie, and arguments in support of his views, as to me it appears a matter of minute importance whether the cranial contents are constant or not. Cappie allows that the first step is "lessened molecular activity, due to exhaustion or other cause," followed by the anæmic state, while the condition is maintained as long as necessary by the uniform pressure of the engorged veins on the cerebral centres. The power of the vasomotor nerves acting *per se*, he will not allow; adding—though some regard them "as veritable physiological demons"—that their power is reflex only, excited by a "mutual vital attraction between blood and tissues," and in support of this he instances the propulsion of fluids in the vegetable world. His views of the action of pressure in this causation are supported by the clinical evidence of hæmorrhage, depressed fracture or hydrocephalus causing coma, and in this connection Sir A. Cooper's case of a man who returned to consciousness from a similar state immediately after trephining is not without interest.

Instead of entirely invoking the aid of the pia matral veins, Mr. Durham attached a good amount of importance to the cerebro-spinal fluid, perhaps unduly, for as Cappie pointed out in opposition to it—(i.) the mechanism is coarse—(ii.) any variation of the cerebro-spinal fluid would interfere with the hydrostatic support of the brain and the nerves at the base; moreover, he could not see what it was to replace in the vertebral canal, and thought the mechanism could not be altered easily enough for such instantaneous effects, as sleeping. Why is such a physical maintaining cause necessary? Cannot the condition of exhaustion with consequent anæmia continue, until such time, extremely variable, as a sufficient stimulus to excite the nerve cells to activity should occur; for such a mechanism would with greater ease explain the semi-waking state of dreams than if the maintenance of sleep is dependent on physical conditions.

A great feature of sleep is its periodicity, though its duration largely depends on individual idiosyncrasy and habit. Waller gives a diagram showing that the noise necessary to wake a person having reached a maximum at one hour is after eight hours' sleep practically nil, when wakening will occur almost automatically perhaps in the manner Sommer suggests.

"Too long sleep," says Haller, "predisposes to slow circulation, with fatness and drowsiness, and is also detrimental to the memory."

Here, if time permitted, I should have liked to digress on the most interesting question of hibernation—a

condition ordained by the Creator to protect those animals whose food, such as insects, is unobtainable during the winter months; but I must only note its similarity to long-continued sleep in the more complete inactivity of the animal functions, with a marked lowering of respiratory and circulatory activity shown by the fall of the pulse in the hamster from 150—15 per min. The chief difference is the extreme fall of temperature, for the hedgehog, dormouse, marmot, hamster and bat become practically poikilothermic, their body temperature only just exceeding that of the atmosphere, which mechanism allows of the least possible tissue change and usage of stored-up O. It is difficult to determine whether animals below vertebrates sleep, though periods of inactivity may be passed as sleep, and as an instance of this in the lower vertebrates Aristotle tells us how fish, which really do sleep, may be surprised in their slumbers.

Considering the extreme case of a hibernating animal, next the long slumber of a reptile after food, and finally the seven or eight hours of healthy man, we may perhaps draw a rough inference that the greater the evolution of the animal the less dependent or reflex is it in its periods of rest.

Before dealing with complete restlessness or insomnia, a few words are necessary on the subject of the incomplete stage, or dreams, which, as Haller pointed out, "ensue when from some cause any one of the mental centres is kept in a state of activity owing to continued or sudden flow of oxygenated blood to it or to some alteration in the quality of the blood"—from either of which causes Cappie notes: "the special molecular vibration, which conditions consciousness, is not entirely suspended, but here the connection with the outer world is severed, the imagination is unrestrained, and the most incoherent association of ideas follows, mocking the limits of time and space." An opposite view—untenable on physiological grounds—first held by Aristotle, and much later by Sir William Hamilton and Mayo,—denies that any moment of sleep is without accompanying dreams, many of which are forgotten or only remembered after a long interval when recalled by some connecting thought.

The treatment of dreaming consists of the use of the milder hypnotics in extreme cases, but first attention should be given to habits and the bowels.

The human being does not appear to be the only dreamer, for Lucretius thought he detected a difference in the dreams of a lap-dog and of dogs of chase, and it could not have been mere conjecture that prompted Sir Walter Scott to write—

"The stag hounds, weary with the chase,
Lay stretched upon the rushy floor,
And urged, in dreams, the forest race
From Teviot Stone to Eskdale Moor."

With this, too, the common experience of each one of us will coincide.

Holding that deep healthy sleep knows no dreams, Blocq assigns to them in certain diseases special characters, as in nervous or in alcoholic intoxication. "For," he says "perhaps the pathological disturbance, though unnoticed in the waking condition, may be sensible asleep, and so produce dreams of a semeiological value," which is further advocated in Kant's epigram, "mental disease is the dream of a waking person." Again, it seems that in circulatory disturbances, dreams are short, end abruptly, bear on tragic events, and fears of death are prominent; affections of the respiratory organs produce horrible dreams of conflicts, with a sense of anguish and suffocation, while the nocturnal terrors of children, usually accompanied by gustatory hallucinations and weight in the epigastrium, point to intestinal derangement. In nervous affections, the repetition of the same nightmare with visions of animals, as rats in alcoholics, has been observed, which may usher in mental aberration and general paralysis, and have a certain influence on the development of the delirium, and lastly, Blocq has noticed that paraplegics rarely dream of walking. This last observation calls up a point worth examination with reference to the share taken in these processes by the special senses. Büchner quite hits the mark in saying "dreams invent nothing, they only reproduce and are entirely subjective," instancing the case of blind people, who never have sensations of sight; in the same field, Prof. Johns has contested the opinion that the blind cannot dream, quoting the case of a boy who dreamt of meeting his brother in the country; he knew the brother by his voice, and was aware he was in the country by the fresh air upon his cheek and the scent of the flowers, thus showing that identification was possible without the sense of sight. I may mention, as still more extraordinary, that the same writer has proved that the blind believe in ghosts—a supposition in the normal individual largely supported by visual sensations. "The past is a dream," said Penelope—a statement to which transposition would give a larger element of truth.

In the extreme condition of sleeplessness the physiological conditions must be continued cerebral excitability or restlessness from some cause, and so it becomes a symptom of importance, although present in a majority of acute and chronic diseases. Blocq classifies causation as predisposing and determining, including under the former heading—

(1.) Emotional constitution and advanced age.

(2.) Occupations involving much brain work or late hours.

While as determining he gives those—

(i.) Arising in nerve centres.

(ii.) Resulting from peripheral stimuli.

(iii.) Due to alterations in the blood.

The majority of brain affections produce insomnia. Some (*a*) acting *per se*, and others (*b*) owing the pain they produce.

In the former class are—

Mania.
Meningitis.
Encephalitis.
Cerebral syphilis.
Cerebral tumours.

And in the two last, insomnia may be of special symptomatic value as giving evidence of the intensity of the headache, of its nocturnal character and perhaps as giving some help in determining its duration. Amongst those acting through pain are many cases of mental aberration where the chief value is in diagnosis.

The commonest peripheral stimuli which will readily occur to all, are—

Wounds or neuralgia.
Dyspepsia and flatulence.
Disturbance of generative system, acting reflexly; and
Cutaneous irritation.

While the determining causes, due to alterations in the blood are easily subdivided into—

(*a.*) Those found in circulatory disturbance—as a first symptom of syncope.

(*b.*) Those due to infections.

Typhoid or acute secondary jaundice, or intoxications.

(i.) Outside the tissues—coffee, tea, alcohol, or tobacco.

(ii.) Inside the tissues—effete products of tissue, change in gout and renal disease.

Another class, not falling under any of the above headings, is essential or psychic insomnia, occurring usually in persons of hereditary nervousness without any direct cause.

Of the active elements in the above diseases we can scarcely even form conjectures, but I may be excused for again quoting Bouchard, who found that the toxicity of urine is markedly increased in febrile disturbances, even of the most transient kind, and by constipation, while Lépine and Guérin's observation that typhoid and pneumonia are especially favoured in this respect—the toxic products of typhoid urine stopping a frog's heart in diastole and those of pneumonia in systole—is very suggestive, and appears well suited to the waste product theory of sleep causation.

Having attached much importance to insomnia as a symptom of disease, I perhaps should not urge its treatment separately from its cause, and practically such a course should only be necessary when the cause cannot be attacked or is unknown; the remedies I shall briefly review, roughly divide themselves into (i.) those aiding the production of normal sleep or "common-sense" methods; (ii.) those producing artificial sleep or narcotics.

Under the head of causation, I spoke of advanced age as a predisposing, and peripheral stimulation as a determining cause, and it is to such classes that common-sense methods are especially applicable. Senile insomnia—the obstinacy of which is perhaps accounted for by degenerative vascular changes—may be attacked through the bowels, constipation being sometimes at the root of the evil, or soothed by small doses of alcohol or bitters at bedtime, and only in extreme cases need the use of drugs, as hop or henbane, be invoked.

Peripheral stimulation will be especially prevalent in children, in whom Dr. Smith finds the following causes chiefly active:—

1. Hunger or improper diet.
2. Cold feet.
3. Worms.
4. Acute febrile diseases.
5. Hereditary syphilis.
6. Habit.
7. Exhaustion of nerve-force, following excitement.

The treatment of these causes is so obvious as to need no comment. I only wish to point out the value of the symptom—often the first—in congenital syphilis. Bromides and opiates should rarely be used in infants.

A regulated diet may be of great importance among adults as treatment for dyspeptic insomnia, which Hollis thought followed any late meal, rich or plain, and was by Sir Dyce Duckworth put down to gastric exhaustion.

Dr. Pye-Smith, in a recent clinical lecture, recommended a small quantity of food before retiring, some hours after any meal, and instanced a common observation of this practice in the use of "nightcaps," which by their heat, bulk and action of the contained alcohol, determine a flow of blood to the stomach rather than to the brain.

Moderate warmth is a very favourable condition to sleep, and especially to be sought after as a valuable aid in the insomnia of weak heart, where the immediate cause is seen in the cold extremities. Warm baths, raised to 110°, have been extensively used in America in dyspeptic insomnia, sometimes followed by massage, and other simple remedies, as the warming-pan and hot poultices, are in universal use.

A detail in treatment, seeming too trivial for mention and yet well worth consideration, is the position assumed during sleep; as raising the head or even the sitting posture may ensure a quiet sleep, from gravity aiding the cerebral circulation.

Exercise in the fresh air will be of much benefit to those forced to lead a sedentary life, or those suffering from cerebral exhaustion, which latter is probably the commonest cause for the commencement of the drug habit, and here perhaps the products of muscular fatigue are needed, as Preyer thinks, to check the continued activity of the motor and other centres.

Ventilation of the sleeping apartments requires our strict attention, for not only is frequent renewal of the air essential, but care must be taken that it contains the necessary moisture, by some such method as sprinkling water on the floor.

Sir Dyce Duckworth has called attention to persistent odours as delaying sleep, such as highly-scented flowers, or even some embrocation on the patient—here the course is extremely simple.

As illustrating a last indispensable condition, I need only refer to the tale of Ptolemy, King of Egypt, who, having passed the seventy interpreters in order, asked the nineteenth what would make one sleep quietly. The

best way, said the counsellor, is to have divine and celestial meditations, and to use honest actions in the daytime.

It is not to be supposed that such remedies are infallible, but they certainly deserve wider attention; and let us be extremely wary of becoming bound down to the use of drugs, as was the man in the mental picture Dr. Wilks has so well drawn, who ordered bromide of potassium for every ill, from quarrels with his relations to business losses. The choice of a suitable drug is, however, often a severe tax on our ingenuity, but the presence or absence of pain may be taken as a good guide, and with this consideration we may divide the drugs into the two classes of (*a*) simple hypnotics and (*b*) hypnotics and also anodynes. Of the first class the most used are *chloral and the bromides;* of the latter, which exert a direct sedative action on the cerebral cells, the most commonly used potassium salt is said to be inferior to the sodium salt in its nasty taste and greater depressing power, which considerations recommend sodium bromide for children especially. Bromides are also invaluable in extreme peripheral irritation, but, when used constantly, diminished brain activity and intellectual lethargy result.

Chloral finds its field of usefulness in vascular excitement, or in acute febrile delirium in children, alone or with the bromides, but it is the drug *par excellence* of insomnia, with high blood-pressure. Persistent resort to its use is disastrous, and in many cases its depressing action on the circulation renders it unsuitable.

Butyl chloral is without risk in cardiac disease, but is most used in neuralgia or functional insomnia.

For *chloralose*, a mixture of chloral and glucose, Hanriot and Richert have claimed great powers in delirium without any dangerous depressing action.

Hypnal, another mixture, containing chloral and antipyrin, has a pleasant taste, and is without causticity; it has the sedative powers of both constituents, and, though not much used, seems suitable for cases of insomnia due to cough with pain.

Chloralamide, first used by Kuy in 20 to 60-grain doses, has but little action on the circulation or the blood-pressure. Though used for the same cases as chloral, their relative power is as 2 to 3 in favour of the latter, but chloralamide is without ill effect on the gastric tract, though headache and giddiness have been said to follow its use—20-grain doses should give sleep in 20 minutes.

With 20-grain doses of *sulphonal* bad effects have been recorded in a batch of 24 out of 40 cases.—(*B.M.J.*, 1890.) Its effect diminishes markedly with frequent use, though much used in mania and senility, being preferred by Garnier to paraldehyde or chloral, who follows Huchard in the use of one large dose. Toney found it more suitable for children than adults. Vomiting often follows 30 to 40 grains. Hutchinson has recorded erythema of the legs following its use. Cumming Mackenzie finds it is the only hypnotic which does not lower the temperature—in fact, it has a slight pyretic action.

It is preferable to chloral as not being a depressant; its taste and odour are unnoticeable, but its solubility is only 1 in 450 of cold water, and so it is best taken two to three hours before bedtime in some hot liquid. Vogt has observed its variability in rapidity and mode of action, and he also finds urea and phosphates in the urine increased by small and diminished by large doses. Hæmatoporphyrin has followed its use, and this also occurs with 20-grain doses of the closely-allied trional—in each case the urine was noticed to be strongly acid, a fault easily remedied by sodium bicarbonate. *Trional* has been used by Collatz in 30-grain doses without bad results; the ensuing constipation must be corrected to avoid cumulation.

Cervello, who introduced *paraldehyde*, denies that it acts on the heart, except through respiration, the centre for which in frogs Wood has shown to be paralysed; in rabbits it also causes asphyxia; which effects Quinquaud has assigned to the formation of methæmoglobin.

Dr. Goodhart has found it unreliable, but useful in aortic disease and as relieving the headache of renal disease, in ½-drachm doses; and Hodgson has advised its use in the same class of cases, in that it does not interfere with the excretion of urine well charged with normal, solid constituents. Finucane has good results with ½ to 1½-drachm doses in mania, and especially general paralysis, where hyoscyamus and opium are contra-indicated.

Fifteen minims of *Tinct. Cannabis Indicæ* will be found useful and safe in chronic heart disease. Fronmüller prefers the tannate (2 to 10 grains) as being less convulsant; it is quite harmless and does not affect any secretions. The discovery of the hypnotic action of *urethane* was the outcome of experiments by Schimedeberg among the ethereal carbamates, when he found that it produced deep narcosis in rabbits without ill effects. He points out that the halogen group of this series, to which chloral belongs, paralyse the vasomotor centres, while chloral has the same effect on the respiratory centre; urethane, however, quickened these movements in a chloralised rabbit. He recommends small doses, as vomiting was frequently produced in dogs.

Coze demonstrates its mode of action by the fact that rabbits under its influence were less readily affected by strychnine—with a diminution of spinal reflexes and peripheral sensations. Dr. Saundby has found gr.ij. a good dose in heart disease and pneumonia where paraldehyde had failed. Its therapeutics appear somewhat similar to those of the bromides in intestinal disturbances.

Radlauer has introduced *somnal*, a mixture of chloral urethane and alcohol; in over fifty recorded cases it acted quickly without ill effects.

Hyoscyamus seems to act as a simple nervous sedative, and is therefore most useful in all forms of mania; in such cases it is only second to opium, and, moreover, is quite harmless in such diseases. Hyoscyamine may be used in melancholia in $\frac{1}{24}$ to $\frac{1}{20}$gr. doses. Hyoscin

which Clouston has pointed out to be a typical cortical motor depressant, has found favour with Malfilatre and Lémoine, who used it in 62 maniacs, $\frac{3}{10}$ to 1 c.m.m. subcutaneously having immediate effect. Occasional temporary intoxication and necessity for larger doses are its chief inconveniences.

Dr. Mitchell Bruce is a great champion of this drug in cerebral excitement; he uses the hydrobromate or hydriodate in $\frac{1}{200}$ grain subcutaneous doses, and has found it harmless even in double pneumonia, and his testimony in its favour in renal disease is supported by Tirard. Full doses may cause failure of respiration, though Dr. Webber, N.Y. has given $\frac{1}{60}$ gr.

Tolerance of *methylal* appears early, and other drawbacks to its use are its cost, and ulceration when injected beneath the skin; it has been given in mania from $\frac{1}{4}$ to $1\frac{1}{2}$ drachm doses.

Sumbul is occasionally used for persistent dreams, and *hop* gains recognition in renal disease, while *lettuce* has a mild action from the contained hyoscyamine.

There is evidence in support of *quinine*, *antipyrin* and *antifebrin* having direct hypnotic actions, and Lauder Brunton has frequently used *strychnine* to bring the nervous system to a state of general fatigue in business and literary men; he only found benefit from the tincture in five to ten minim doses. Brush gives similar evidence.

Sir William Broadbent has used *mercury* for the insomnia which Murchison showed to be due to the high tension of lithæmia; it appears to, in some way, correct the extreme acidity.

Lactic acid in 8 to 10-grain doses has been tried by Maragliano, following Preyer, for mania and melancholia. It is expensive and inferior to chloral, and had previously failed in Germany.

Hypnotics and anodynes.—*Chloroform and ether* are rarely used, and so *opium*, in some form or other, occupies the entire field, seeming to search out the seat of pain wherever it is, and so relieves the insomnia. So well known is it that I need only mention a few points.

Apart from its action as an anodyne it is superior to chloral in producing less subsequent cerebral anæmia; in cases of vascular excitement it is well combined with antimony or aconite.

Jastrowitz has pointed out the superiority of opium to morphia in senile insomnia, repeating the usual caution in relation to heart disease and habit, and notes that these drugs are primarily sedatives and hypnotics only in large doses; here may be remembered the opinion of Stillé that opium acts in moderate doses by making the brain anæmic, while Hammond thinks that in large doses it causes venous congestion. Stephen Mackenzie opposes the deeply-rooted idea of general danger in renal disease, having injected liq. morph. hydrochlor. ɱx. in granular kidney, with good result—an action he attributes to freeing the blood-vessels from the toxic spasm; uræmic dyspnœa has also in his hands yielded to morphia. Dr. Loonns, of N.Y., who has made this practice his own, has given half a grain of morphia in uræmic coma, and declares "he has never seen a case of fatal narcotism." Cumming Mackenzie, in a paper—to which my obligations are immense—gives tables showing decrease of urine with slight per cent. increase of albumen after morphia in a case of chronic Bright. Clouston is of opinion that loss of appetite follows even moderate doses, though frequently increased body weight follows in senile insomnia the use of morphia, which produces an almost natural sleep.

The constipating action of opium is perhaps accounted for by the experiments of Nothnagel, who considered that the ascending constriction, following the direct application of morphia to the intestine, was due to stimulation of nerve fibres inhibiting peristalsis.

Loewenmayer has used *codeine* in 400 cases, and chiefly with success in side pain of phthisis. He finds it similar to morphia—less active, but less dangerous.

And now, gentlemen, that I have come to the end of my scattered, and, as I am well aware, totally inadequate remarks on this vast subject, I can only thank you for your kind and continuous attention, well worthy of a better object, and trust that the subsequent discussion will justify your self-denial in leaving your firesides this evening.

A CORRESPONDENT has sent us for publication the following interesting "items copied from a tailor's bill" lately received by one of his patients. He informs us that "the gentleman came under my notice last autumn, for acute Bright, due to chill caught rabbit shooting, and treated by 'chartreuse.' I knocked him off all liquor and put him on milk. For result see below."

K. A. F., Esq., *Dr.* to R. F. S., Tailor, etc.

1894.		s.	d.
Oct. 10.	3 vests let out	3	0
13.	2 " "	2	0
	Norfolk jacket let out	2	0
Nov. 10.	Dress trousers and vest let out ...	2	0
24.	Dress coat let out	2	6
17.	Norfolk jacket let out all over ...	3	6
	Breeches let out	1	0
Dec. 1.	Trousers let out	1	6
		17	6

Appointment.

HODGSON, J. W., M.D., C.M. Aberd., M.R.C.S., has been appointed Consulting Physician to the Exmouth Dispensary.

Acknowledgments.

WE have received the Journals of St. Thomas's Hospital, St. George's Hospital, St. Bartholomew's Hospital, and the London Hospital. Also the Annual Report of the Liverpool Medico-Chirurgical Institution and the inaugural address of the President, Mr. Chauncey Puzey, on "A Surgical Revival," and contributions from our South African and Vienna correspondents.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

MARCH 9, 1895.

Tubercular Disease of the Testis.

CLINICAL LECTURE BY MR. CLEMENT LUCAS.

GENTLEMEN,—I have lately had under my care in the Hospital two cases of tubercular disease of some portion of the genito-urinary tract, each of which originated at a different centre. One starting from the kidney spread downwards, the other, to which I propose to confine my remarks to-day, commenced in the testis and spread in an upward direction.

Let us consider here the continuity of the genito-urinary tract anatomically, we shall then perceive what an inconvenience this continuity produces in such infective diseases as tubercle and gonorrhœa.

The kidneys are in direct continuity with the bladder by means of the ureters, the bladder with the urethra, which carries the urine away through the meatus externus. Again, each testicle is in direct continuity with the urethra by means of the vas deferens, the vesicula seminalis, and the common ejaculatory duct. The prostate communicates by its ducts, which open into the prostatic sinuses on the floor of the urethra. You will now see how tubercle starting in one testicle may spread along the vas, affecting the vesicula seminalis, common ejaculatory duct, and thus into the urethra. It may then make its way, by an inverse route, to the other testicle, or into the prostate, or finally into the bladder, along one or both ureters, and thus terminate its career of continuity in one or both kidneys. This process may, on the other hand, in a precisely similar manner, commencing in one kidney, spread until it finally reaches the testicle.

In a woman this spreading of disease from one tract to the other seldom occurs.

Out of 9 cases of tubercle of kidney in women, in one only was the generative tract tuberculous; whereas, in 32 cases of tubercular kidney in the male, the prostate was involved in 9, the vesiculæ seminalis in 6, and the testis in 4.

On the other hand, in 45 cases of tubercular disease of the generative organs in the female, in only one was the urinary tract affected.

R. G., æt. 21, a grocer's assistant, a pale, thin, delicate-looking man, was admitted on January 10th last, for "abscess of right testicle with discharging sinus."

Family history.—Patient knows nothing of his father or mother, who died early; he has one sister, 23, alive and healthy. Here let me point out to you, that when a patient comes to you, such as this man, remembering nothing of his parents, there is strong presumption that they died of consumption, unless he be illegitimate.

Previous history.—Patient suffered with "inflammation of the eyes" last year, and had very bad diarrhœa last summer.

Present illness began about four months ago, when the right testicle was observed to swell up rather quickly; no history of injury to the testicle in any way. An abscess formed which was opened by a doctor; it has never healed up. He improved under treatment and went back to work. Since then he has complained of abdominal pains, headache, biliousness, and has vomited on one occasion.

On admission.—The left testicle was found to be enlarged as regards the epididymis. The

swelling, affecting mainly the globus major, was hard and nodular; the left vas was thickened and hard. Testicular sensation was present.

On the right side the whole testicle was swollen, more so below; swelling hard and nodular, involving both testicle and epididymis; vas much thickened. Skin was reddened, and adherent at upper and front part, just below the root of the penis. At this spot there was a sinus discharging a yellowish curdy pus. There was fluctuation over the lower part of the tumour, apparently due to fluid in the tunica vaginalis. On examination, *per rectum*, the prostate was found to be enlarged, especially on the right side, and the right vesicula seminalis could also be felt to be enlarged. In the right inguinal canal was a swelling, one and a half inches long and one inch across, moving with the testicle, ill-defined in outline; elastic in consistency, and giving fluctuation on manipulation. Skin over it was normal.

This case, then, showed very well the salient points of tubercular disease of the testicle. With regard to *age*, the disease is commonest in young adults; this man is 21; then it is a disease which goes on to suppuration, and, lastly, it begins in the epididymis and spreads to surrounding parts of the genito-urinary track, and may secondarily affect the body of the testis.

Tubercular disease of the testis is a disease which almost invariably first attacks the epididymis. It has been thought by some that the tubercle bacillus, finding its way by continuity of the mucous membrane of the urethra into that of the generative tract, is obstructed in the globus major of the epididymis by its convoluted arrangement, and that here it sets up trouble. Others maintain that the difference in the circulation of these parts may account for this part being the first attacked.

In some cases it is difficult to understand how this can occur. I remember a child, a year old, who was brought to me with both testes suppurating; both parents were suffering from phthisis. Here we may suppose that the bacillus carried through the circulation lights upon an ill-developed and weak organ, which forms a fruitful field for its destructive activity.

Tubercular disease of the testis may follow an injury, especially so when there is tubercular disease elsewhere, or after gonorrhœa in people of delicate constitution it may occur.

The lecturer knew of a case in which a man, whose wife suffered from phthisis and leucorrhœa, probably tubercular, acquired a tubercular testis. In such a case one might suppose the bacillus to have travelled in the same way as the gonococcus in gonorrhœa.

Signs, symptoms and diagnosis:—

(1.) The onset is insidious in young subjects, and causes little inconvenience.

(2.) It is painless until suppuration occurs; testicular sensation is not lost.

(3.) It is generally confined to the epididymis, most often starting in the globus major, where it is usually more advanced even if the globus minor be affected.

(4.) There may be a hydrocele present, but this seldom happens.

(5.) Vas is thickened, but not the whole cord to the same extent as in malignant disease.

(6.) The other testis, the prostate and vesicula seminalis may be enlarged.

(7.) The presence of the tubercular disease elsewhere.

(8.) If it is seen late the presence of sinuses, which, on examination, are found to lead down to the globus major or minor, is very diagnostic of the disease.

(9.) Enlargement of glands. The deep lumbar glands may enlarge, and where suppuration of the scrotum has occurred, the superficial glands of the inguinal glands may become enlarged.

(10.) In syphilis the body of the gland is affected: there is irregular enlargement, usually associated with hydrocele, which is of small amount. Testicular sensation is soon lost, and there is the history of infection. It has little tendency to suppurate, but frequently leads to fibroid atrophy.

(11.) Malignant disease.—Carcinoma and sarcoma. There is rapid growth in the body of the testis. The spermatic cord is thickened, disease spreading by lymphatics and veins, and there is loss of testicular sensation.

(12.) Gouty orchitis is most commonly met with past the middle period of life, and occurs in people of the gouty diathesis.

(13.) Mumps. In epidemics of mumps the testicle may be swollen when there has been no enlargement of salivary glands. There is elevation of temperature.

Course.—I have pointed out to you how the disease goes on to suppuration and spreads. In addition, remember that a discharge may occur and healing take place, and the mass may remain as a permanent quiescent lump or become calcareous. Other troubles may set in,

however, by the dissemination of tubercle elsewhere, resulting in general tuberculosis or in phthisis. A tubercular lump is always a source of danger.

Treatment. — In early cases, constitutional treatment sometimes meets with partial success. The patient should be placed under the best hygienic conditions, preferably at the seaside. Diet should be plentiful and nourishing. When suppuration has taken place, I should always strongly advise the complete removal of the organ and the scrotum where perforated should also be freely excised. Where this is refused, the best you can do is thoroughly to scrape out the tubercular cavity and fill it with iodoform and glycerine.

In our case, excision of the right testicle was performed, and the inguinal canal split up to clear out the abscess of the cord. The cord was ligatured close to the internal abdominal ring. We could not remove the whole disease as it involved both testes, prostate, and one vesicula seminalis, so we attacked where it was most active, hoping under favourable conditions the patient might throw off the remainder. The patient made great improvement, and the wound entirely healed up. Previous to the operation, the enlargement of the prostate caused frequent micturition. The operation was performed on the 15th January, and at the time of his discharge (30th) patient had no trouble with his water, and said he felt "much better."

When seen a month later, the prostate was found to be less in size, and no suppuration had taken place in the remaining testis. The patient's general health was improving, and he was no longer troubled with frequent micturition.

Royal College of Physicians, 1895.

Lectures of the Present Year

Will be delivered at the College, Pall Mall East, on each of the following Tuesdays and Thursdays, at five o'clock.

Milroy Lectures.—Dr. A. Newsholme, March 5, 7, 12, 14, "The Natural History and Affinities of Rheumatic Fever."

Goulstonian Lectures. — Dr. H. D. Rolleston, March 19, 21, 26, "The Suprarenal Capsules."

Lumleian Lectures.—Dr. G. Fielding Blandford, March 28, April 2, 4, "The Diagnosis, Prognosis, and Prophylaxis of Insanity."

(By Order of the President),

WILLIAM FLEMING, *Bedel.*

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	12, 32.	Mitral stenosis and regurgitation.
	16, 19, 22.	Mitral regurgitation.
	38.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	40.	Chlorosis.
	41.	Mitral stenosis. Pneumonia.
Philip	18.	? Aortic aneurysm.
	24.	Ulcerative endocarditis.
	35.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
Stephen	1.	Mitral regurgitation.
	6.	Mitral and tricuspid regurgitation. ? Aortic stenosis.
	16.	Ulcerative endocarditis.
	29, 40.	Aortic stenosis and regurgitation. Mitral regurgitation.
	36.	Mitral stenosis and tricuspid regurgitation.

Alimentary System and Abdomen.

Mary	1, 34, 36, 43, 45.	Gastric ulcer.
	37, 42.	Constipation.
Philip	15.	Diarrhœa. Anæmia. Wasting. ? Cause.
	35.	Ascites. ? Cirrhosis. ? Chronic peritonitis.
Stephen	9.	Tuberculous peritonitis.
	10.	Stricture of œsophagus.
	20.	Appendicitis.

Typhoid Fever.

Mary	39.	
Philip	5, 7.	
Stephen	25, 32.	

Genito-Urinary System.

Mary	8, 10.	Diabetes mellitus.
Philip	10, 14.	Diabetes mellitus.
Stephen	19.	Diabetes mellitus.
Mary	23.	Chronic tubal nephritis. Abortion.
Philip	6.	Chronic tubal nephritis.
Stephen	14, 17, 22.	Chronic tubal nephritis.

Respiratory System.

Mary	15.	Broncho-pneumonia.
	17.	Phthisis.
	20.	Pneumonia. Pleuritic effusion.
	26.	Bronchitis and emphysema. Moveable kidney.
	28.	Pneumonia, following parturition.
	30.	Pleurisy.
	49.	Broncho-pneumonia.

Philip 12, 20. Phthisis.
19, 27. Pleurisy.
23. Pneumonia.
25. Broncho-pneumonia. Herpes labialis.
26. Fibroid lung. Bronchiectasis.
28. Bronchitis and emphysema.
Stephen 4, 7. Bronchitis and emphysema.
13. Empyema. Phthisis.
31. Syphilitic laryngitis.

Miscellaneous.

Mary 14. Ulceration of legs.
Philip 2, 8, 34. Acute rheumatism.
3. Osteo-arthritis.
4. Gonorrhœal rheumatism.
Stephen 39. Acute rheumatism.

Influenza.

Mary 18, 19, 20, 25, 50.
Philip 9, 29, 37.
Stephen 11.

Nervous System.

Mary 6. Chorea.
20, 27, 29, 44. Hysteria.
24. Exophthalmic goître.
33. Melancholia.
Philip 9. Epilepsy.
22, 36. Syphilitic myelitis.
30. Double facial and auditory paralysis.
31. Left hemiplegia.
32. Aphasia.
Stephen 12. Cerebral tumour. Optic atrophy.
38. Myelitis.

In the Surgical Wards.

Cases under Mr. Davies-Colley.

Lydia 8. Old amputation for perforating ulcers. Ulcers in stumps.
Cot. Hypospadias.

Cases under Mr. Lucas.

Accident 4. Ruptured urethra.
13. Compound fracture tibia and fibula.
Lydia 13. ? Sarcoma of superior maxilla.
14. Carcinoma mammæ.
Cot. Hare-lip. Cleft palate.
Job 1. Recurrent synovitis of knee. ? Damaged internal semilunar cartilage.
5. Ganglion of wrist.
17. Inguinal hernia.
25. Double tubercular testicle. Excision of one testicle.

Cases under Mr. Golding-Bird.

Martha 1. Ununited fracture of clavicle. Bone in three pieces.
3. Hæmorrhage into knee-joint.
7. Rheumatoid arthritis of knee.
Cot. Nævus of scalp. Large ulcer.
Lazarus 13. Fistula in ano.
20. Varicocele on left side. Congenital hydrocele on right.

Case under Mr. Jacobson.

Samaritan . Gangrene, both legs and one arm, following frost-bite. Amputation of three limbs. Patient doing well.

Case under Mr. Symonds.

Martha 14. Ectopia vesicæ. Plastic operations.

Cases under Mr. Dunn.

Martha 11. Tumour of lower jaw. ? Cyst, etc.
Lazarus 2. Malignant stricture of rectum.
Naaman 5. Long tendon and biceps slipped out of place.
9. Ulcer of face. ? Epithelioma. ? Syphilitic.
21. Loose semilunar cartilage.

Case for Diagnosis.

We publish to-day a solution received from a Bristol correspondent of the Case for Diagnosis, which was given in our last issue, together with that furnished us by Mr. Floyd, to whom we are indebted for the very interesting particulars of the case.

The case you gave for diagnosis last month was possibly one of ulcerative endocarditis of the pulmonary orifice, associated with localised abdominal suppuration. The thrill in the first left space suggests an organic lesion of the pulmonary orifice, which, if not congenital, was probably malignant in nature. The varying dulness in the left flank suggests a dilated stomach. The fluid contents of a dilated stomach may pull the organ over into the left loin, and although the dulness may not disappear, as in this case, on turning the patient on to the right side, it leaves the left side. It is possible that the varying dulness was due to an enlarged flaccid spleen, that could not be felt, falling behind a portion of the distended transverse colon, but I do not think this probable. Some dulness remained in the left flank. It must have been rather too much to the left for an enlarged spleen, and may have been a localised collection of fluid.

The ascites was probably due to some obstruction of the portal vein. We may suppose a gastric or probably duodenal ulcer to have set up inflammation in the neighbourhood of the head of the pancreas, with possibly a small localised collection of pus. The dilatation of the stomach, if present, may have been due to a contracting ulcer of the pylorus, or to pressure of adhesions outside. The dulness in the left loin may have been due to a collection of pus spreading to the left loin, over the surface of the pancreas to spleen and left kidney, or may have been due to a second perforation near the cardiac end of the stomach. Should there

have been malignant endocarditis of the left side of heart, as well as the right, such a collection, if present, may have been secondary to a septic infarct of the spleen.

T. F.

The Correct Diagnosis and Post-mortem Appearances.—The case was an extremely interesting one. The loud, variable cardiac murmurs suggested ulcerative endocarditis, but the eyes were found to be normal and there was no albumin in the urine. There was no history of alcohol or syphilis to be obtained from the patient or his relations. A fellow-workman told us afterwards that patient had drank to excess for two years. The true diagnosis was only revealed at the post-mortem. The liver was then found to be extremely cirrhotic; the new connective tissue showing an unusually large proportion of connective tissue corpuscles, occasionally resembling embryonal connective tissue, showing the cirrhotic process was proceeding very rapidly. Hardly any fatty degeneration (Dr. Lancaster). Spleen was large and soft and the heart dilated, but otherwise healthy. The great rise of temperature for five days before death was probably due to erysipelas; if so, however, it was not at all characteristic. Taylor mentions pyrexia as an occasional complication of cirrhosis, and Dr. Lancaster tells me of a case sent in as liver cirrhosis, who eight days before his death developed and kept up a temperature of 102 to 104 till his death. The murmurs must have been hæmic; they were the loudest cardiac murmurs I have ever heard. The patient, however, was never very anæmic. The blood was examined and found normal.

Swansea. S. G. FLOYD.

Methods of Attaching Mr. Newland-Pedley's Porcelain Crown.

Preparation of root.—The root should be cut nearly level with the gum, not flat, but just following the general contour of the gum, and this can be done readily with carborundum wheels.

Selection of crown.—A model of the mouth will be found useful, especially if the articulation be close. It is very important that the measurement between the hole and the anterior surface of the crown should correspond as closely as possible with the space between the pulp-chamber and the anterior margin of the root, for, if these measurements agree, the pin will pass readily into the root canal, and the anterior surface of the crown, when fitted, will be exactly flush with the root in front, and will not require polishing. It is of little consequence if the porcelain crown be rather too large for the root at the sides or back, for it can readily be reduced by the carborundum wheel, and any part not in sight need not be polished.

Selection of pin.—Note that pins made for the upper front teeth are almost round, whilst those for the bicuspids are flattened. The pin selected should fit the crown as closely as possible, but it must be remembered that if the pin is wedged into the crown the tooth will split like an ordinary "tube-tooth." The pin should be of elliptical shape throughout its entire length, but should taper towards the point. Six sizes of split pins are made for two-rooted bicuspids. The points of the pins can be reduced with the file, or with the corundum disc on a dental engine.

Fitting the pin.—This is best done with ordinary fissure burrs, but if the Herbst's burr be used, great caution will be required to prevent it from getting jammed into the canal and thus causing pain. Only the minimum of tooth substance should be removed that is requisite for the fitting of the pin, for the less the cement used, the stronger will be the attachment of the crown. A pair of pliers with grooved beaks will be found useful when it is necessary to bend the pin.

Fitting the crown.—The crown should be roughly fitted, and then an accurate model of the root should be taken by covering the base of the crown with gutta percha and pressing it on to the root. Over this an impression is taken, in which the crown carrying the gutta percha is replaced, and a small model is made to which the crown can be closely fitted. Fine-fitting can be done in the mouth by painting the crown and touching the root with a burr or wheel; or a piece of thin articulating paper can be used.

Attaching the crown.—The pin should be serrated with a file, and the root canal should be well grooved at short intervals by means of a wheel burr swept round the cavity. The root canal should be dried and the apex filled in the usual way. Attach by:—

(1.) *White cement*, mixed thin. It is generally best to cement the pin to the crown first. When this has set, the pin can be coated with cement, and the root canal lined with the same material applied on a pellet of cotton wool wound round the tip of a burr or Morey drill. Press the crown home, and hold it in place till the cement is firm.

(2.) *Sulphur.*—Melt a little sulphur in the crown, heat the pin and press it into place. Or, cement the crown to the pin first, then, as suggested by Mr. Douglas Wright, fill the root canal with chips of sulphur, heat the pin and press it home. The hot pin melts the sulphur, and they adhere firmly when cool.

(3.) *Amalgam.*—The pin can be fixed in the root with amalgam, and the crown attached with cement or sulphur. Or, a disc of amalgam can be interposed between the crown and the root; cement or sulphur being used elsewhere. In badly-decayed roots the canal can be filled with amalgam packed round the pin, which is then withdrawn, and the operation is completed when the amalgam has set. The withdrawal of the pin is facilitated by slightly coating it with hot wax.

(4.) *Gutta Percha.*—Can be used in the root, or a disc of gutta percha can be merely interposed between the crown and the root.

(5.) *Silicates.*—With a low fusing power can be used to fix the crown to the pin.

Personally, I can only speak of osteo in the attachment of these crowns, and if the holes are ribbed, the pins and root canals serrated and dry, and if the cement is carefully applied, a firm attachment is certain. As regards the strength of the cement, we know that 100 pounds weight of pig-iron can be suspended to a pin cemented into a porcelain front tooth. Pins made of "dental alloy" stood less strain than those of German silver, and I found that the dental alloy pins stretched before the cement gave way. I am not aware of any movement of the jaw by which a direct downward strain can be brought to bear upon a tooth. For additional strength the root can be capped and a gold band can be fitted beneath the gum. The chief source of failure is in the error of enlarging the root canal too much, for then we have to rely entirely on the strength of the osteo, amalgam, or sulphur. The front teeth are much easier to adjust, and with them success is more certain than with bicuspids. At the back of the mouth there is just a chance that the root canals may be imperfectly shaped, the crown defectively fitted, and the pulp-chamber lined with thick mucus. Then, if the cement is deluged with saliva before it has set, and the articulation is inadvertently raised so that the whole force of mastication falls on the one porcelain tooth, no surprise should be felt if a crown comes off or splits.

Guy's Hospital Debating Society.

The Debating Society met in the Smoking-room on Saturday, February 23rd, to discuss a motion—"That the tendencies of modern journalism are prejudicial to the common weal." Mr. Hamblin Smith was seconded by Mr. Coleman, and opposed by Messrs. Higgins and Pakes.

The attendance was small throughout, but the debate maintained its interest to the end, the speeches being characterised by fluency and vigour. But the two sides were at cross-purposes—the mover's party maintaining, what none will doubt, that there is much that is bad in modern journalism; while the opposition drew attention to the glories of a past journalism and the brilliancy of leading periodicals, which, again, is past contention. No one would deny the vulgarity of *Ally Sloper* or the inimitable merits of Addison's *Spectator;* but what was wanted was a broad survey of the whole field of modern periodicals, general and special, a discussion upon their functions, upon the growing tendency towards criticism instead of mere authentic fact, and upon the comparative forces in the direction of demoralisation and moralisation of our modern newspapers. It was only in the last quarter of an hour that the opposing sides really met, had a sharp brush, and separated, leaving the mover victorious by 14 votes to 12.

Mr. Hamblin Smith made a speech that was excellent for its arrangement, delivery and liveliness; in fact, he was almost the only speaker of the evening who showed any method in treating the different points of his subject. He deprecated the hunger after news of the modern newspaper—news political, news medical, news personal—news of any kind that has not yet gained publicity, however desirable it may be that it should be kept secret. He took objection to the exaggerated praise that is bestowed on some persons and denied to others at the discretion of the editor. He deplored the action of the Press in reporting divorce cases and other matters of morbid interest. He pointed out the harm done through the criticism by the Press of legal cases, or of scientific discoveries, such as that recently of antitoxin. Perhaps his best point was a denunciation of the illiterate and slovenly writing of most modern papers. Finally, he took the bread out of the opposer's mouth by denying that the papers had any influence in forming public opinion.

Mr. C. P. Higgins, in opposing the motion, treated at length of the history of the subject. It was unfortunate that his speech should have been read from notes, the effect being thus considerably impaired. An interesting account was given of the history of modern journalism, of the great services it had rendered to the public, and a catalogue was given of the great names connected with journalism, and of the stimuli given by such periodicals as the *Edinburgh Review* to the publication of articles on special subjects by the respective authorities in those subjects. But the opposer appeared to forget that no one would deny one word of what he had said; and it was only at the end of his speech, where, in a few illogical sentences, he tried to slur over the scurrility and Philistinism of the Press, that he touched upon the point at issue. Mr. Higgins's delivery, however, was undoubtedly good, and his voice clear and distinct.

Mr. E. Coleman thought that the newspapers were disappointing in their gross superficiality, and tended to a great amount of reading without any accumulation of knowledge. There was the danger, too, of misrepresenting matters of International importance; and finally he noted—being entirely oblivious to the great prominence given last year by the *Daily Graphic* and many other papers to the need of increasing the Imperial Navy—a total lack of patriotism amongst the journals of the day. The speech was, in its way, interesting; the delivery was good and the speaker's manner lively, but the argument was hardly to the point.

Mr. W. C. Pakes made an eloquent peroration on Patriotism; praised the modern journalism as tending to the glorious freedom of John Bull, and discounted its immoral effect upon that gentleman and his family. Mr. Pakes exhibited much fluency of style and alertness in parrying sudden attacks, but his arguments were not well worked out.

Mr. E. Ivens Spriggs made a speech, excellent both as to matter, delivery and arrangement. Admitting the glories of the old journalism, he mourned the demoralising effect upon the world in general, and himself in particular, of the modern journalism arising

from America, for which Mr. W. T. Stead was in the main responsible.

Mr. A. W. Ormond, in a creditable maiden speech, made a few good points on the other side. He should, however, address his audience rather than his boots.

Mr. A. P. Allan should not have risen to speak after a member of the same opinions as himself. He considered that the Press did useful work for the hospitals and for the public.

Mr. J. Fortescue-Brickdale made a genuine old-fashioned Tory speech, descrying everything that was modern. His remarks may have been a little disjointed and hardly to the point, but they were amusing, and, to a certain extent, original.

Mr. Anderson added poetry to the debate—a poetry of thought and diction, which, like most poetry, must not be examined too closely, otherwise it is found to be hardly to the point and not exactly correct.

Mr. Pendred attacked both sides, considering the whole debate to be "much ado about nothing."

The Rev. the Chaplain reverted to practical proposals for the improvement of the Press; and we quaked in our editorial shoes as suggestions were made for our editorial benefit as to enlarging the scope of the Gazette.

Mr. Rice, in a short though masterly little speech, brought the debate to the point. He weighed the good and the evil tendencies of the modern newspaper, and declared that the evil "had it."

Mr. Higgins, in reply, stigmatized Mr. Pendred as a static Englishman, and as a young barbarian at play. A few other equally irrelevant points were raised.

The Mover maintained his position in a few bright, pithy sentences.

After the division, a vote of thanks was passed to Mr. F. G. Hopkins for taking the chair, and the House adjourned at ten o'clock. F.

Meana Schnitz'l;

OR,

STUDIES IN LITTLES.

No. I.

Your self-appointed Special Correspondent in Vienna ventures to offer a few remarks—general and particular—upon things in particular and things in general. As One of the wild inhabitants of the place remarked, in the course of a conversation, the differences between various nations in reality resided in mere matters of detail. He pointed his moral by instancing the matters of eating, drinking—How much? or How little? or *What of? concern us not—the Clothes, too, said he,* are in their end and object and in the attainment thereof . . . . but here we arrive at the study of our first "Little." Probably the effect of the sudden total annihilation of all buttons, which Carlyle once thought upon, would not be more electric than the sudden introduction of the form of dress frequently used here—on a Thursday or a Saturday afternoon at Guy's. Your Correspondent is not writing for the ladies' column in a "Weekly," and so contents himself with describing much of the dresses of the patients in a somewhat vaguely negative manner as "stark, staring, stripped." So much for the first; the second shall also be rather an absence than a littleness.

Is it that the German language is too difficult, or is it that Viennese comprehension is dull—what in fact is it that makes it so hard to explain and to be understood—that London, the greatest city in the world, possesses no real University? No University professors and their myriad hosts of underlings? Marvellous! unintelligible! say they, only a miserable Examining Body! Indeed, many are only to be stopped in the course of such talk, by reference to the New University that is to be—some day;—a veritable *Deâ ex Machinâ*—whose existence is yet too nebulous to wash away any fantastic airy fanes reared upon its foundations.

And so—on to the next. Not a novelty, but certainly a detail! Take, for example, the proper treatment of a Paquelin's Thermo-cautère. How is it that sometimes this excellent apparatus refuses to respond quickly? Here a neat little wire support is arranged, so that the platinum point rests bathed in the flood of flame engendered by a spirit-lamp. From the reservoir is it *divorced until the last moment. With handle enveloped* in sterile iodoform gauze;—to be touched by none but the unanointed surgeon. When used, and wanted no more, and whilst yet glowing brightly, again is it sundered from the nutrient store of naphtha, by the simple removal of the india-rubber tube. Thus does it happen that no deposit of carbon takes place within the holy of holies—the contact of naphtha breath and platinum will be sure and close. Ready, aye ready! Nor are "coels*" of fire heaped on anyone's head.

Another absence. Naïvely answered: No, say they, we have not used sponges lately, perhaps only 10, perhaps 12, years ago we saw the last of them. Excepting always occasional use as an elastic dressing. Then, again, to the more ridiculous. What a fund of latent wit is to be found in the burning question of "Heilserum" and its efficacy. At the fancy dress balls, there is sure to be one individual with a wooden horse provided with a beer-tap—thrust in its side regardless of anatomy. The opponents, the advocates of the deleterious action of the serum, are advised to use the "Antiheilserum"—a marvellous fluid which checks the baneful influence of the grosser liquid. The purveyor of wooden rocking-horses, the owners of merry-go-rounds, all are supposed to add to their incomes by tapping their gee-gees for serum. "In your jugs, this door!" Come, the children with mugs and jugs to get their daily pint, for the modest sum of 2d.—4d. And so *ad infinitum*—nearly. Also thus are the varieties of courses of instruction—the multidollar-stricken American hesitates not to rid himself of much superfluous cash. Attention to the detail. What of a two-guinea course of operations on the ear? Assuredly cheap for so large a subject. And subjects are cheap and plentiful! Δ.

* Apology for misprint coals in following number.

The Pavy Gymnasium.

THE COMPETITIONS.

The Fencing and Gymnastic Competition for prizes kindly presented by Dr. Pavy was held on Monday, the 25th ultimo. Considering the amount of illness prevalent among the students, it was a matter for congratulation that the energetic honorary secretary, Mr. Duncan, was able to obtain a fair number of competitors. In the Gymnastic Competition exercises were set upon the horizontal bar, parallel bars, vaulting horse, rings, and rope, and on the whole the form shown by the individual performers was creditable, Walling, Richardson, and Henry being best in this respect. Three squads were arranged of three each, and at the end of the Competition that under the leadership of Walling was declared the winning one by the judges, Mr. Spon, and Serjeant "Smith" (of the Chelsea Barracks Gymnasium). The constitution of the squads was as follows:—

(A.) H. Walling (leader); J. Matthews and N. H. Pike (winners).

(B.) B. F. Henry (leader); Noel Davies and B. Instone (second).

(C.) J. Richardson (leader); E. I. Spriggs and C. T. Anderson (third).

There were but a few marks between squads B and C. In order of merit, the first four competitors were Walling, Richardson, Henry, and Pike.

The Fencing Competition produced some exciting bouts, and there was marked improvement on last year's form. There were six competitors, Staff-Serjeant Young, the instructor, and Serjeant "Smith" acting as judges, Mr. Spon as referee.

In the first round C. E. Michael met E. T. Jensen, and after an easy bout defeated him by 3 to 2. The next bout between A. H. Finch and G. E. Duncan produced a good deal of surprise, in that the latter was somewhat easily defeated by 3 to 0, his opponent's long reach being too much for him. In the third bout A. Scott-Turner had little difficulty in disposing of W. E. Hills to the tune of 3 to 0.

In the second round Scott-Turner drew a bye, so Michael met Finch. The latter did not at once settle down, and Michael drew first blood. Finch replied with two hits in rapid succession; Michael, however, was too clever for him, and finally won by 3 to 2.

The final produced a keen and scientific exposition between Michael and Scott-Turner. At first Michael gained the advantage, the score standing at 3 to 0 in his favour. Scott-Turner now began to press, and after some rapid exchanges the score stood 3 to 2. Each now began to be cautious, and the "play" was very good. Michael scored again and Scott-Turner replied with two others, the last stroke going in favour of Michael, who thus defeated last year's winner by 5 to 4. Scott-Turner then fenced and defeated Finch by 3 to 1 for second prize.

THE ASSAULT-AT-ARMS.

The Ladies' Night was a success last year, and it was thought that something on a more extensive scale might reasonably be carried out this year. Expectation proved to be right, for certainly the evening which we spent in the Gymnasium on the 28th ultimo was most enjoyable, and the performance the best that has ever been given by the members of the Gymnasium.

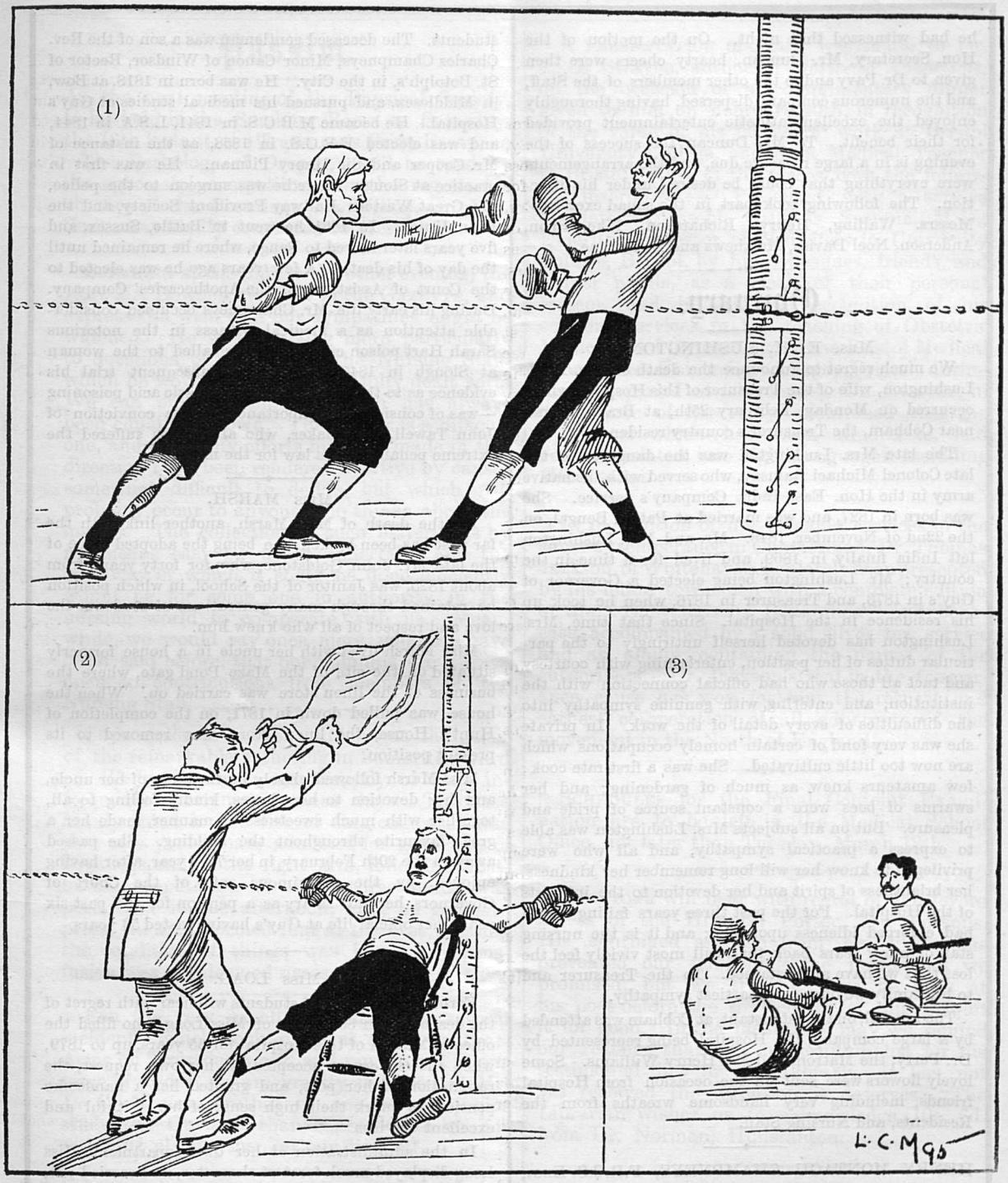
There was a good audience, including Dr. Pavy, Dr. and Mrs. Shaw, Messrs. Higgens, Dunn, and Hopkins, Dr. Fawcett, and Sisters Clinical, Dorcas, Out-patients and Martha. During the interval refreshments were served in the dining-hall.

The gymnasts were greatly aided in their performances by Messrs. W. L. Furrell and W. M. Smith, of the St. Peter's (Brockley) Literary and Athletic Society, whose various feats were much appreciated, and we are much indebted to them for their kindness in assisting the members, whose numbers, alas, were sadly reduced through *Influenza*.

Proceedings began with a set of exercises and voluntaries on the horizontal bar, concluding with a well arranged set-piece, in which a prominent part was appropriated by an intelligent (?) "foot-piece"! A keen and vigorous exhibition of boxing was given by E. Morgan and P. F. Henry, whose performance forms the subject of two of our sketches, and seemed especially to delight the ladies! Fencing between Michael and Scott-Turner, and exercises on the vaulting horse by the squad, brought the first part to a close.

Tea and coffee over, a start was made with a single-stick encounter by the Instructor and G. E. Duncan, which was followed with sympathetic and abiding interest. The squad then gave an exhibition on the parallel bars, some of the voluntaries producing much enthusiasm. Considerable amusement was caused by the cock-fighting, in which Spon's side proved victorious over Henry's by 2 to 1. Scott-Turner with the bayonet was opposed to Sergeant Young, who defended himself to good purpose with the sword. The former seemed to find his engine of war, by reason of its weight, an exceedingly awkward weapon to persevere with; the encounter, however, was none the less interesting, and afforded much food for reflection as to "chance" in the game of war. The grand salute in fencing, very prettily and gracefully carried out by Duncan, Scott-Turner, Finch and Staff-Sergeant Young, brought the assault to a close.

Dr. Pavy then presented the prizes to the successful competitors in the Fencing and Gymnastic Competition, and expressed his pleasure at being once more amongst the students; he was particularly gratified to find what excellent use was being made of the Gymnasium, it was hardly necessary for him to tell them how important a thing it was to exercise their bodies as much as their minds, and in conclusion he hoped they would continue to obtain that exercise, so necessary to their health and strength, by such graceful performances as



(1.) Messrs. P. F. Henry and E. Morgan give a turn with the "mittens." (2.) A "breather"—and an energetic second.
(3.) Cock-fighting—a successful "throw."

At the Assault-at-Arms in the Paby Gymnasium.

he had witnessed that night. On the motion of the Hon. Secretary, Mr. Duncan, hearty cheers were then given to Dr. Pavy and to the other members of the Staff, and the numerous company dispersed, having thoroughly enjoyed the excellent athletic entertainment provided for their benefit. To Mr. Duncan the success of the evening is in a large measure due, and the arrangements were everything that could be desired under his direction. The following took part in the squad exercises: Messrs. Walling, Henry, Richardson, Pike, Spon, Anderson, Noel Davies, Matthews and B. Instone.

Obituary.

Mrs. E. H. LUSHINGTON.

We much regret to announce the death of Mrs. E. H. Lushington, wife of the Treasurer of this Hospital, which occurred on Monday, February 25th, at Brackenhurst, near Cobham, the Treasurer's country residence.

The late Mrs. Lushington was the daughter of the late Colonel Michael Ramsay, who served with the native army in the Hon. East India Company's service. She was born in 1827, and was married at Patna, Bengal, on the 22nd of November, 1848. Mr. and Mrs. Lushington left India finally in 1869, and lived for a time in the country; Mr. Lushington being elected a Governor of Guy's in 1873, and Treasurer in 1876, when he took up his residence in the Hospital. Since that time, Mrs. Lushington has devoted herself untiringly to the particular duties of her position, entertaining with courtesy and tact all those who had official connection with the institution, and entering with genuine sympathy into the difficulties of every detail of the work. In private she was very fond of certain homely occupations which are now too little cultivated. She was a first-rate cook; few amateurs knew as much of gardening; and her swarms of bees were a constant source of pride and pleasure. But on all subjects Mrs. Lushington was able to express a practical sympathy, and all who were privileged to know her will long remember her kindness, her brightness of spirit and her devotion to the interests of the Hospital. For the past three years failing health had enforced idleness upon her; and it is the nursing staff of a few years back that will most vividly feel the loss that we have all sustained. To the Treasurer and to his family we offer our heartiest sympathy.

The funeral, on the 1st instant, at Cobham was attended by a large company, the Hospital being represented by Dr. Perry, the Matron, and Mr. Henry Williams. Some lovely flowers were sent on the occasion from Hospital friends, including very handsome wreaths from the Residents, and Nursing Staff.

HENRY MONTAGU CHAMPNEYS, F.R.C.S. Eng., L.S.A.

By the death of Mr. Henry Champneys, which occurred after a few hours' illness, on February 11th, from angina pectoris and syncope, Guy's has lost one of her oldest students. The deceased gentleman was a son of the Rev. Charles Champneys, Minor Canon of Windsor, Rector of St. Botolph's, in the City. He was born in 1818, at Bow, in Middlesex, and pursued his medical studies at Guy's Hospital. He became M.R.C.S. in 1841, L.S.A. in 1844, and was elected F.R.C.S. in 1858, at the instance of Mr. Cooper and Sir Henry Pitman. He was first in practice at Slough, where he was surgeon to the police, the Great Western Railway Provident Society, and the Eton Union. In 1861 he went to Battle, Sussex, and five years later moved to Penge, where he remained until the day of his death. A few years ago he was elected to the Court of Assistants of the Apothecaries' Company. During his early life Mr. Champneys occupied considerable attention as a medical witness in the notorious Sarah Hart poison case. He was called to the woman at Slough in 1845, and at the subsequent trial his evidence as to the cause of death—prussic acid poisoning—was of considerable importance in the conviction of John Tawell, the Quaker, who afterwards suffered the extreme penalty of the law for the murder.

Miss MARSH.

By the death of Miss Marsh, another link with the far past has been broken, she being the adopted niece of the late Mr. John Goldstone, who, for forty years, from about 1825, was Janitor of the School, in which position he retained through many generations of students the love and respect of all who knew him.

Miss Marsh lived with her uncle in a house formerly situated on the site of the Maze Pond gate, where the business of the linen store was carried on. When the house was pulled down in 1871, on the completion of Hunt's House, the linen store was removed to its present position.

Miss Marsh followed closely in the steps of her uncle, and her devotion to her duties, kindly feeling to all, together with much sweetness of manner, made her a great favourite throughout the building. She passed away on the 20th February, in her 78th year, after having enjoyed, by the unanimous vote of the Court of Governors, her full salary as a pension for the past six years, her official life at Guy's having lasted 53 years.

Miss LOAG.

Former generations of students will hear with regret of the death, in her 80th year, of Miss Loag, who filled the office of Matron of this Hospital for 35 years, up to 1879, when the Governors accepted, at her own request, the resignation of her post, and granted her a handsome pension to mark their high sense of her faithful and excellent services.

In the administration of her own department Miss Loag displayed much force of character, and carried out, with the sanction of successive Treasurers, many reforms with vigour and discretion. The good name and welfare of Guy's, let us hope, is the ambition of all its officers—in Miss Loag, certainly, they found a sturdy champion.

Passim.

At the next meeting of the Physical Society, to be held in the Smoking Room on Saturday, the 16th instant, the Treasurer's Prize Essay, on "The Pathology of Dropsy," will be read by the successful competitor. In the regrettable absence of the President (Dr. Wilks), Dr. Pye-Smith has kindly consented to preside.

Speaking at the debate the other evening, the Rev. Mr. Bowden referred to the Gazette, and expressed a wish that our sympathies might be widened. He was referring more particularly to questions of interest to the Nursing Staff, which he would fain see more fully dealt with. We can only say that the wish has always been equally our own. The matter is a difficult one, and the many efforts hitherto made in this direction have been rendered abortive by causes somewhat difficult to define, but which will probably occur to anyone who thinks about the matter. The collection of such material is by no means easy for us to undertake, and the only way in which it could be done efficiently would be for some one in authority in the nursing world to co-operate with us. Meanwhile, we would say once more, what we have often said before, that our columns are always open to contributions from members of the Nursing Staff.

Such cases as the one which was the cause of the remarkable gathering in Samaritan ward on Wednesday last, are happily of very infrequent occurrence in these days. The case briefly noted in the list of surgical cases was that of a young man, admitted for gangrene of both legs and of the right arm, following frost-bite. Amputation of these three limbs was performed in the afternoon, and, on going to press, we are informed that at the first dressing the condition of things was hopeful. Transfusion was not deemed necessary.

For the very excellent sketches of several incidents which took place at the Assault-at-Arms on Thursday week, and reproduced in our issue of to-day, we are greatly indebted to Mr. L. C. Munro, brother of one of our junior students. Our best thanks are due to him for so kindly placing them at our disposal.

Several small articles of adornment were found after the Residents' dance. They may be obtained by the rightful owners on application to the secretary, Mr. H. M. Stewart.

A presentation of plate was made to Dr. J. G. Swayne, author of *Obstretic Aphorisms*, on the occasion of a complimentary dinner given to him on February 20th, in recognition of the value of his 50 years' work at Bristol University College, and as a Medical Teacher in Bristol. One of the pieces bore the following inscription:—"Presented with a service of plate to Joseph Griffiths Swayne, M.D., Emeritus Professor of Midwifery in University College, Bristol, by his colleagues, friends, and former pupils, as a mark of their personal esteem, and in grateful recognition of his eminent services in the teaching of Obstetric Medicine and Gynæcology in the Bristol Medical School and University College, Bristol, during the long period of 50 years." Dr. Swayne, in the course of his reply, mentioned that the *Aphorisms* which had been alluded to, had been translated into eight languages, including Hindustani.

In recognition of his valuable services in the cause of temperance in Cumberland, Dr. Thomas Jackson, of Whitehaven, has lately been presented by his fellow-townsmen with a complete edition of the "Encyclopædia Britannica" and book-case, accompanied by a solid silver tea service and an album containing the names of the subscribers. Dr. Jackson's zeal in the temperance cause has won for him the respect and earnest co-operation of all adherents of the movement in the North of England.

Schedules for the Final Conjoint Examination are to be left in the Medical School Office, not later than Tuesday, March 12th.

Everyone will hear with regret of the severe illness of the Hospital Porter, Mr. Parsons. His continued absence from his duties has prevented our publishing the particulars we promised, but we trust he may be back at his post before the time comes for him to quit it for good. In the meantime, may we remind our readers that the subscription list for his testimonial lies in the Library. It has not yet received the attention it deserves. The Librarian wishes us to acknowledge 10s. 6d. from Dr. Norman, Hunstanton.

We are compelled to hold over until a future date several contributions of interest, including a series of "Knee Cases," "On the Zambesi," and some more correspondence on "Specialism."

We regret that the various charitable expeditions which have been made by some of the Nigger Troupe should, owing to misapprehension, have given rise to such feeling as is expressed (in another column) by a correspondent, "Out of the Swim." Surely it should hardly be necessary to point out to him that the arrangement of such expeditions is usually a matter for the Committee alone to decide upon.

Our readers will cordially join us in our expressions of sincere sympathy with Mr. Lushington and his family in the loss they have recently sustained. On the same day as the funeral of Mrs. Lushington, a memorial service was held in Chapel, at which as many of the Sisters and Nurses who were able to do so, attended. The Chaplain officiated.

Those of the First Year's Students who have not yet done Chemistry, are reminded of the fee of £2 10s., to be paid at the Medical School Office, for materials, etc., before they can attend these classes, which begin in the first week of May.

We have once again to heartily congratulate our cross-country representatives in winning for us--for the fourth year in succession—the United Hospitals' Hare and Hounds Challenge Cup. This result was brought about by the splendid performance of H. A. Munro, who was easily first, and by the clever running of our second string.

The much-delayed tie in the Surrey Association Cup Competition between Guy's and Ewell came off on the ground of the latter on Saturday last. Our chances were considerably lessened from the fact that we were without the services of some of our "cracks"—in the back division especially; the match was none the less a good one, and Ewell thoroughly deserved the handsome victory they obtained.

The Guy's Association team, or all that is left of it, will play University College Hospital at Richmond next Tuesday. We hope there will be a large attendance of Guy's men to assist the back division in their efforts!

The Inter-Hospital Rugby Cup Ties are becoming gradually narrowed down, in spite of weather and its attendant evils. Guy's have been, perhaps, somewhat unfortunate, in that they have as yet played no game in the competition. St. Mary's scratched to us on account of influenza, and now King's, who, it will be remembered, defeated Charing Cross in the first round, have done ditto for the same reason. The first meeting of Bart.'s and Thomas's was productive of great excitement, and in consequence considerable attention was directed to the second encounter, which took place yesterday, and resulted in a win for Thomas's by 1 goal 1 try (8 points) to nil.

Guy's Hospital Christian Union.

On Thursday, February 28th, in connection with the Christian Union, Dr. Herbert Lankester delivered a lecture upon "The Work of a Medical Missionary," in the Court-room of the Treasurer's house, kindly lent for the occasion. There were present the Matron, the Assistant-Matron, several of the Sisters and other members of the Nursing Staff, and ladies from the Women's School of Medicine; Dr. Stevenson (who took the chair), the Chaplain, and a good number of Students, bringing the total up to about a hundred.

Tea and coffee having been served, the meeting began at half-past four with singing, and with prayer offered by the Chaplain.

Dr. Stevenson, in welcoming Dr. Lankester to Guy's, referred to him as a distinguished St. Thomas's man, and consulting physician to the Church Missionary Society. Medical Missions especially commanded the interest of all connected with hospitals, and it gave him great pleasure to preside on that occasion.

In the course of his lecture, Dr. Lankester gave an account of the management of an Eastern hospital, with the arrangements for out and in-patients, and dressings. Some striking figures were quoted, showing that in one of the C. M. S. hospitals the number of major operations performed in a year equalled that at Edinburgh Royal Infirmary, while the percentage of deaths was smaller. He spoke of the great need for Medical Missionaries in various parts of the world; of the vast and interesting material available for the exercise of professional skill, especially in surgery; and of the splendid opportunities for earnest religious work which such a career affords.

The lecture was illustrated by a number of excellent limelight views, including some of special interest, such as the photograph of a cured necrosis of tibia, and the very graphic representation of a case of leprosy. Other pictures showed the hospital buildings in use in India, many of them of large and solid proportions, the wards and the patients.

Hearty votes of thanks were given to the lecturer and chairman before the meeting ended. The lecture was the first effort of the kind the Christian Union has made and was thoroughly successful, although a test examination prevented some men from being present. There are now four Guy's men in the mission field. A sum of £2 13s. was subscribed for Medical Missionary work.

From the Gazette's Special Pathologist.

All specimens — particularly those of solid tissues— should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

J. R. A., Sherborne.—No tubercle bacilli could be found in the sputum.

W. A. G., Chatham.—We have examined sections from the kidney and a portion of the liver away from the portal fissure, but in neither specimen is there any evidence of tuberculous disease. Beyond changes due to decomposition, both viscera appear healthy.

E. A. A., Tunbridge Wells.—No tubercle bacilli could be found in the sputum.

A. E. S., Middlesboro'.—No tubercle bacilli could be found in the sputum.

W. H. D., Preston Park.—No tubercle bacilli could be found in the sputum.

W. A. E. W., Rugby.—A few tubercle bacilli are present in the sputum.

C. M., Bournemouth.—No bacillus diphtheriæ could be found either on the membrane or in the culture.

J. B., Tunbridge Wells.—Tubercle bacilli are present, but only in small numbers.

W. H. M., Kidderminster.—The specimen shows superficial ulceration and much inflammatory growth in the submucous tissue, but there is no evidence of malignant disease.

W. H. M., Kidderminster.—The growth from lip is a squamous-celled epithelioma, deeply ulcerated in the centre.

T. F., Oldham.—In this specimen no tubercle bacilli have been observed,

H. H. Du B., Weymouth.—The gland is traversed by narrow bands of epithelioma, in which birds' nests are very abundant.

PATHOLOGIST.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Guy's "Dis-Guysed" Minstrels.

Sir,—I have noticed, in some recent issues of the Gazette, very flattering reports relating to performances of the "Guy's 'Dis-Guysed' Minstrels," at various charitable entertainments outside the Hospital walls— for the objects of which there can, of course, be nothing but praise—but, as a member of the original Nigger Troupe, which was organized for the entertainment of the patients during the recent festive season, shall I be considered, by impartial judges, unreasonable or "hypersensitive" in expressing my surprise, and perhaps a warmer feeling, at having received absolutely no intimation of these expeditions from their originators? Surely common courtesy should have prompted some notice or apology to members of the original troupe, who were not included on these occasions; in the absence of such the "slight" is marked and not easily forgotten.

Apologizing for the length of this letter, I beg to remain, yours, etc., "OUT OF THE SWIM."

Guy's Hospital.

Inter-Hospital Association Cup.

Dear Sir,—I learn with sorrow that we are not at all certain of holding the Inter-Hospital Association Cup this year. In view of the approaching Cup ties, I venture to offer the following suggestion:—Last Wednesday week a keen and scientific exposition of the game was witnessed by numerous spectators at Honor Oak Park. The match was between a dozen Rugger men and eight or nine of the Socker team, and the result was a crushing defeat of the Socker men by ten goals to one. The game was very one-sided in more ways than one, for to an unbiassed spectator the Rugby men seemed to possess a considerably larger share of dash and science than their opponents; moreover they had not the happy knack of "getting their tails down" that was too evident on the other side. There is an idea prevalent in the Hospital that the Cup team consists of the best men available; if this is the case, surely the Association Selection Committee have no alternative but to choose the Rugger men *en masse*, or eleven of them at least. In conclusion, let me remark that the Rugby team sometimes train for their Cup matches. Can such a thing be said of their Association colleagues?—Yours truly, SOCBY.

Guy's Hospital.

Appointment.

Cressy, G. J., L.R.C.P., L.M., L.R.C.S. Irel., has been re-appointed Honorary Surgeon to the Mansfield and Mansfield Woodhouse District Hospital.

The Scientific Diagnosis of Nervous Disease.

III.

"In the first place, the structure of the spine should be known, for this knowledge is requisite in many diseases."—Hippocrates. *On Articulations.*

C. Spinal Lesions.—

α. Extra-medullary.

β. Intra-medullary.

γ. Lesions of canda equina (strictly come under α, but convenient to make a separate group).

α. *Extra-medullary lesions* may produce—

1. Root-symptoms, and later on
2. Cord-symptoms.

1. Root-symptoms are again divisible accordingly, as they depend on—

(a.) Anterior roots.—Irritation of these produces twitching or tonic spasm in the supplied muscles, and ultimately, loss of skin and tendon-reflexes, paresis, R. D. and atrophy.

(b.) Posterior roots.—Irritation of these produces pains, hyperæsthesia, trophic skin lesions, and ultimately, loss of all reflexes and of every form of sensibility, tactile, painful, thermal, muscular, postural, often combined with a "girdle-sensation." Root-symptoms may be seen in cases of injury, meningitis, compression (caries or growth), and posterior root-symptoms *alone* are seen in *Tabes*, and in Dr. Hughes Bennett's remarkable case which may be termed *Pseudo-tabes* (*Trans. Clin. Soc.*, 1885, vol. 18).

Symptoms which closely simulated those of Tabes were produced in this case by the posterior roots throughout the dorsal and lumbar regions being imbedded in a sarcomatous mass. The following symptoms of Tabes were :—

Present.	*Absent.*
"Lightning-pains."	Romberg symptom
Anæsthesia.	(Tottering with the
Analgesia.	heels together and
Retarded sensation.	eyes shut).
Lost knee-jerks.	Eye-changes of every
Ataxic gait.	kind.

Symptoms of *Tabes* may arise from interruption of the co-ordinating impulses in three different situations.

(1) *Peripheral nerves.*—M. Dejerine first demonstrated the neuritis of the nerve-endings in skin and muscle.

(2) *Posterior roots.*—Van Deen and Claude Bernard demonstrated experimentally that section of the posterior roots in animals produced extreme and typical ataxia without any loss of motor power. Dr. Bennett's case, mentioned above, is a confirmatory experiment of the same sort, planned and carried out by Nature without any "vivi-section" license.

(3) *Posterior columns.*—The first lesion of tabes to be discovered. Compare ataxic paraplegia.

2. Cord symptoms may be due to—

(*a.*) Mechanical pressure, or to

(*b.*) Myelitis secondary to compression;

and are again divisible into two groups according as they depend upon—

i. Interference with central functions of ganglion cells at level of the lesion, *e.g.*, abolition of a particular reflex, or muscular atrophy, bedsores, incontinence, etc.; or,

ii. Interference with conducting functions of the cord, "uppards and downards," *e.g.*, paresis, impaired sensation, increased reflexes, and tendon-jerks.

The pathological causes which may give rise to a condition of *Compression-paraplegia* are—

(1.) Caries in spine.
(2.) Hydatids in spine.
(3.) Growths in spine.
(4.) Growths in membranes.
(5.) Chronic hypertrophic meningitis.
(6.) Acute meningitis.
(7.) Meningeal hæmorrhage.
(8.) Aneurysm eroding the vertebrae.
(9.) Growths in the cord itself, etc.

A Total transverse lesion of the cord gives rise to—

In all parts at and below the level of the lesion.

(1.) Complete paralysis with—
(2.) Muscular flaccidity.
(3.) Complete loss of all forms of conscious sensation.
(4.) Complete absence of tendon or deep reflexes (the above are all *permanent*). There may be complete and permanent loss of—
(5.) The skin or superficial reflexes, and
(6.) The organic reflexes (reflex evacuation of bladder and rectum).

The recent literature of the subject which "affects one of the most fundamental principles in neurology" may be considered to begin with Bastian's paper (*Med. Chir. Trans.*, vol. 73, 1890), and a critical digest of nearly 40 contributions on the subject which have since followed will be found in the spring number of *Brain*, just issued (by Dr. Ernest Reynolds). Bastian stated that the loss of skin-reflexes was constant and permanent, but Bowlby, in the same volume of *Transactions*,

published cases in which the plantar reflex ultimately returned, while Hughlings Jackson has observed a case in which the knee-jerks ultimately returned. A case in point was that of Amelia H., æt. 70, in *Mary, 32*, during September and October, 1894, under Dr. Pitt. *Epithelioma of hand—secondary growth in D_2 vertebra—total transverse solution of cord at this level.* Condition, complete flaccidity, with permanent absence of *all* reflexes (tendon, skin, bladder) over a period of 8 weeks preceding death.

Of the 40 contributions alluded to above, the case recorded by Bruns, of Hannover (*Archiv für Psychiatrie*, Band xxv., Heft 3) is worth almost as much as the other 39 put together. The patient died on the 106th day, after a fracture-dislocation severing the cord between C_7 and D_1 vertebræ. There was advanced pyramidal degeneration throughout the lumbar region, as well as trifling degeneration in the peripheral nerve-trunks and muscles of lower limbs, but cord and nerve-roots at this level were quite healthy, except for the secondary degeneration in the cord; these conditions certainly could not account for the absence of the knee-jerk. "The case affords positive proof of lasting paralysis and flaccidity of the muscles of the lower limbs, with loss of knee-jerks and skin reflexes, and permanent paralysis of bladder and rectum, in result of total transverse lesion of cord." (Abstract of Bruns' paper by Sherrington, *Brain, 1895*).

It has been laid down as an axiom that in cases with flaccidity and absent reflexes, solution is complete, and surgical interference useless. Thorburn, however, mentions a case (*Surgery of the Spinal Cord*, p. 48,) of hæmorrhage into the grey matter in the cervico-dorsal region (practically the only region in which hæmatomyelus occurs) where all reflexes were abolished. The man lived more than two days after the injury, so the old "shock-explanation" would scarcely apply. Thorburn (as we shall see later) states that "the abolition of the reflexes is a result of isolation of the spinal centres from their *cerebellar* connections." Bruns points out that in many cases of cerebellar disease the knee-jerks are absent. The writer has seen them permanently absent in a case of tumour in the frontal region under daily observation for four months.

A Transverse lesion confined to the grey matter, such as hæmorrhage (hæmatomyelus), gives rise to—

(1) Paralysis, generally, but not necessarily, always permanent (one case seen by the writer began to improve $1\frac{3}{4}$ years after the occurrence).

(2) Loss of thermal and painful sensations (tactile sensation unimpaired).

(3) Absence of reflexes or, perhaps, more frequently increased tendon-jerks with

(4) Rigidity.

In hæmorrhage of any sort the onset is sudden and immediate. The chief points of distinction between *meningeal* and *intra-medullary hæmorrhage* are the following (Bastian):—

Meningeal.	*Intra-medullary.*
Not very uncommon.	Rare.
Paralysis and anæsthesia generally slight and transient.	Paralysis and sensory disorder prolonged and often permanent.
Bedsores, incontinence and cystitis rare.	Bedsores, incontinence and cystitis frequent.
Painful and thermal sensations not interfered with necessarily.	Painful and thermal sensations abolished.
Spasm occurs early.	Rigidity occurs later.
Often recovers completely.	Never recovers completely. Often fatal.

The increased tendon and skin reflexes in the present case, with stiffness of the right leg, paresis, anæsthesia and pains, *might* have been caused by compression, which, in that case, would have to be above the cervical enlargement of the cord. There was no confirmatory sign of any lesion at this level, such as caries, growth or meningitis.

β. *Intra-medullary lesions.*—

Before proceeding to the method of ascertaining the vertical and horizontal extent of these, it will be as well to make a few remarks upon the functions of the cord.

These are (1) Central.
(2) Conducting.

The "reflex-centres" in the cord are not really purely reflex in man, whatever they may be in monkeys. As previously stated, in a total transverse lesion (say in the cervico-dorsal region), the knee-jerks and usually the skin-reflexes (plantar, gluteal, cremasteric, abdominal, epigastric), are permanently abolished with absolute muscular flaccidity, although the reflex-arcs concerned may be perfectly uninjured. So long as the lesion is incomplete the tendon-reflexes may persist or reappear, becoming ultimately exaggerated with rigidity and clonus. The exact meaning of all this is still, alas! far from clear, but a sort of *merely provisional* interpretation will probably be of some value.

As a clinical fact, sclerosis of, or pressure upon, the lateral pyramidal tracts (in the absence of a total transverse lesion) always produces increased knee-jerks, clonus, rigidity, spastic gait, etc. Similar tendon-phenomena may occur as the result of the post-epileptic condition (often a valuable test for the "Drunk or Dying" type of case in the surgery) of functional disease (not necessarily "Hys."), or of so-called voluntary mental processes (increased attention, malingering, etc.). Now, the mechanical effect of a capsular hæmorrhage is to plough up the fibres which should conduct impulses to the anterior cornual cells, and hence immediately results paralysis with absent or diminished knee-jerks. [I rather fancy that occasionally rigidity occurs whilst the bleeding is taking place, supposed to be due to irritation of the pyramidal fibres by the effused blood, or again a day or two later as the result of inflammatory softening

in the surrounding brain-substance, but I dare not dogmatise upon this point at present.]* Six months later, however, when lateral sclerosis is well established, the *paralysis* remains more or less *in statu quo*, but the *diminished jerks* are replaced by clonus, rigidity, etc.

For a long time the explanation adopted in fashionable neurological circles of this "late rigidity" was that of the French school (Bouchard, Charcot et Cie), viz., that the sclerosis produced increased irritability of the anterior cornual cells, presumably by the sclerotic scar-tissue pinching the undegenerated pyramidal fibres, or their reticular termination in the grey matter, and hence, so to speak, keeping them awake. In time a Hughlings Jackson arose, which knew fact and not fashion, and pointed out (*Med. Times and Gaz.*, Feb. 12, 1881), that—

(1) Paralysis was a negative condition.

(2) Absent or diminished jerks was also a negative condition.

(3) The ultimate supervention of sclerosis, itself also a *negative* condition, could not *per se* convert the preceding conditions into

(4) One of rigidity, clonus, etc., a clearly *positive* one. (Two minuses do not make a plus in physiology, whatever they may do in algebra.)

Hence Jackson inferred that lesions of the pyramidal tracts interfered with downward restraining impulses from somewhere, which had previously had the effect of keeping a rein upon the knee-jerks. His difficulty was to explain total transverse lesions, which were then erroneously believed to give rise to rigidity, etc. But what the caterpillar did not eat, that the locust devoured, and Dr. Bastian arose (soon followed by Mr. Bowlby) and showed that total transverse lesions were not followed by rigidity, but by *flaccidity* and permanent absence, at any rate, of knee-jerks. The long and the short of it may be roughly stated thus: When you elicit a knee-jerk, an afferent impulse is generated in the intra-tendinous nerve-endings which affects certain cells at level of $L_{2\&3}$, and (here is the point) as the result of the coöperation with this afferent impulse of tonic, augmentor impulses descending from the *cerebellum* along the pyramidal tracts tending to strychninise the anterior cornual cells + antagonistic inhibitory impulses descending from the *cerebrum* (? ? optic thalamus) along the grey matter (?) tending to physostigminize these precious cells, there is shot out from them a resultant impulse which whizzes down the anterior crural nerve and makes the quadriceps contract. The exact etiquette prevailing between these contending impulses is, of course, a matter for dispute. Bastian's idea seems to be that the inhibitory impulses from the cerebrum simply say to the cerebellum, "*You shan't,*" and hence the channels through the cord are not so much torn up by the passage of rival impulses, as that there is a mere blocking of the augmentor impulses either at the departure platform when starting or else where they join the main line. Jackson would point out that the cornual cells have the always difficult task of serving two masters, and that rigidity, when it occurs, differs in character according to which flag the cornual cells are for the time being sailing under. Thus, in post-hemiplegic rigidity he would regard the cerebrum as having *surrendered* to the cerebellum. With great courtesy he was kind enough to show the writer a number of sketches of a "tetanus-like" rigidity or opisthotonus occurring in cases of cerebellar disease (tumour, hæmorrhage, etc.) Such cases, on the other hand, he would regard as examples of the cerebellum having *capitulated* to the cerebrum.

Thus Bastain would consider increased knee-jerks the result of *unrestrained*, Jackson the result of *unantagonised* cerebellar influx. Reynolds (*Brain*, 1895) points out that the fact of this "extra leakage of cerebellar energy," having the tendency to increase up to a certain point, may be only an evidence of gradually lessening resistance (? ? in the pons), because "all nerve actions, whether normal or abnormal, become easier, and recur more readily the more frequently they are repeated." [The worst of it all is that in total lesions of the *grey* matter, such as Hæmato- and Syringomyelus, instead of being diminished, the knee-jerks are not infrequently increased. And again, to still further complicate the profound intricacy of the whole matter, Bastian refers to the case of a girl with Pott's disease and markedly increased reflexes, in whom no degeneration whatever of the pyramidal tracts could be detected. I do not see, however, what is to be gained by shirking or ignoring these difficulties].

It is easy to remember that the *cerebrum*, and not the cerebellum, is the author of the *inhibitory* impulses, if we remember that *the highest* function of man and man's nervous system is *Self-control* (alcoholism and G.P.I., which is only a chronic and more permanent drunkenness, are evidence of this), and that they follow the lateral tracts, is easy to remember from the well-known spastic conditions associated with all forms of lateral sclerosis.

The spinal cord can be roughly divided into several superposed segments, according as the cells, concerned with various muscles and movements, can be grouped off into various levels. Hence, a lesion confined to the cells of one particular segment, will pick out for atrophy the particular muscles nourished from this segment. For example, a little girl, under Dr. Beevor's care, recently came under the writer's notice. Systematic investigation showed that the following muscles on the right side (and these muscles only) were weak and wasted, viz.:—Triceps (musculo-spiral),

Lower half of Pect. major (anterior thoracics),
and Latissimus dorsi (long subscapular).

All these three muscles are innervated from the segment at the level of the C_6 nerve-roots. Hence, there was no doubt that she must at some previous time have had a

*Bastian, I believe, states that a hæmorrhage cutting off both *cerebrum and cerebellum* causes *absent*, but one separating *cerebrum* only, *increased* knee-jerks in the first instance.

local poliomyelitis (infantile) limited to this particular segment—the illness being so slight that the mother had not noticed it. The above illustrates well what is meant by a "spinal grouping" of the affected muscles. It is clear that it could not depend on any peripheral lesion.

To localize a spinal lesion, we have to determine as accurately as possible—1. its *Vertical* extent.
2. its *Horizontal* extent.

[It does not seem to make any great difference in the long run as to which is investigated first, *provided both are completely examined into.*]

1. THE VERTICAL EXTENT is learnt by ascertaining *seriatim* the presence or absence of the following reflexes. The Jacksonian saying that "The clue that we possess for traversing the tangled labyrinth of mental (and nervous) diseases lies in Evolution and its reversal Dissolution," * is frequently quoted with a certain amount of mysticism, but it only means that man is a segmented animal of the order *Annelida*, and to understand him we must begin either at his head or his heels and work downwards, or, better still, upwards. The following may be taken as approximately correct (Bastian) :—

Cervical region - -	Lesions here may involve respiration, pulse, flushing, or pallor of head and neck, continued priapism, hyperpyrexia, contraction or dilatation of pupils.
Cervico-dorsal region -	Scapular reflex = C_6–$D_{2\text{ or }3}$.
Upper dorsal region -	Epigastric reflex = D_{4-7}. } Priapism *may* occur with lesions here.
Lower dorsal region -	Abdominal reflex = D_{8-12}. }
Upper lumbar region -	Cremasteric reflex = $L_{1,2}$.
Mid lumbar region -	Knee-jerk = $L_{2,3}$.
Lower lumbar region -	Gluteal reflex = $L_{4,5}$.
Sacral region (= lower part of lumbar enlargement)	Plantar reflex and Ankle clonus } = S_{1-3}, Bladder and rectum (? ? here or above knee-jerk).

The following table of spinal nuclei of muscles (slightly altered from Thorburn) may also be of service :—

C_4 root -	Supra- and infra spinatus.
	Teres minor (?)
C_5 root -	Biceps and brachialis anticus.
	Deltoid and upper half of pectoralis major.
	Supinator longus and brevis.
C_6 root -	Subscapularis, teres major and latiss dorsi.
	Lower half of pectoralis major.
	Pronators.
	Triceps and serratus magnus.
C_7 root -	Extensors of wrist.
C_8 root -	Flexors of wrist.
D_1 root -	Interossei and other intrinsic muscles of the hand.

* The same thing was pointed out by Laycock 50 years ago under the name of the Law of Dis-volution.

Ross (*Brain*, January, 1888) showed that the distribution of anæsthesia depended on the embryological position of the limb. The highest roots supply the radial, the lowest the ulnar side of the upper extremity, the others being distributed in numerical order. Hence, the higher the mischief in the cord, the further will the anæsthesia extend from the ulnar towards the radial side.

Hence, the *upward* extent of the lesion may be ascertained without difficulty, provided the peripheral portions of the various reflex arcs are uninjured. The *downward* limits are also ascertainable, unless the lesion is total, in which case every reflex below the lesion is lost.

(2) THE HORIZONTAL EXTENT of the lesion is ascertained by investigating the various conducting tracts in the cord : comprising—

(1.) *Grey Matter* : this, besides the cells constituting the reflex centres enumerated above, through the same or different cells presides over the nutrition of muscles, skin, nails, joints, etc. It also conducts *painful* and *thermal* sensations upwards. [Gowers thinks that they cross over in the posterior (grey) commissure to the Antero-lateral ascending tract of the opposite side].

[It is *supposed* also that it conducts tonic augmentor impulses from the cerebellum, helping to initiate the tendon (and ? skin) reflexes.] Examples of interference with these functions are seen in *Syringomyelus* (which is practically a destruction of the grey matter), exhibiting (1) analgesia, athermia ; (2) amyotrophy ; (3) trophic changes in skin, joints, etc., such as glossy skin, eruptions, scars and cracks on the finger-tips, white patches on the nails, and osteo-arthritic changes (see case reported in GAZETTE, August 18th, 1894). In *Hæmatomyelus* where the grey matter is ploughed up by effused blood. The functions impaired are exactly the same as in syringomyelus and the only unaccountable thing is that in both the knee-jerks may be increased. *Infantile palsy* (poliomyelitis anterior acuta), and *Progressive muscular atrophy* (ditto chronica) where the anterior cornual cells are the victims of acute and chronic disease respectively. *Myelitis* in lumbar region with acute bed-sores. [*Analgic panaritium* (Morvan's disease) = syringomyelus + peripheral neuritis.] The joint and bony changes (brittleness, fractures), and even muscular atrophy occurring in *Tabes*.

(2.) The *White matter* includes the following tracts—

(*a*). Direct and crossed pyramidal tracts conveying downward impulses for movements and for inhibiting the reflexes (cerebral).

(*b*). For afferent tactile sensation (? where).

(*c*). Afferent sensations from muscle-nerves = posterior columns (Tabes and ataxic paraplegia and Friedreich's disease are examples) : perhaps the Direct cerebellar tract is also concerned with impulses of a similar nature, as it goes to the cerebellum and is affected

in the last two diseases, and occasionally in *Tabes*. (*d*). & (*e*).—Sense of posture, and (?) sense of locality.

According to the horizontal distribution of the effects of the lesion across these vertical columns in the cord, the lesion may be determined to be either

(A) A random lesion such as inflammation, *e.g.* myelitis; hæmorrhage may be of a random nature especially if meningeal, or it may be confined to the grey matter (see above hæmatomyelus), or hæmorrhagic myelitis, or lacerations of the cord-substance or intra-medullary growths.

[Intra-medullary growths differ from meningeal growths in that in the former the root-pains are absent or trifling, unless the growth begins close to the posterior horn; the cord symptoms are often bilateral from the first and occur simultaneously with, or before, instead of after root-symptoms. Extensive muscular atrophy is common. The course of the disease is gradually progressive.]

γ. Lesions of the cauda equina, such as effused blood, or dislocation, may be considered here. The great point is that bladder and rectum escape.

It is a curious fact which Thorburn draws attention to, that though the whole of the nerves of the cauda pass the level of the lesion, those which lie nearest the middle line, and escape lowest (*i.e.*, the sacral roots) always suffer most. The diagnosis is from:—

(1) *Tabes* (distinguished by ocular symptoms, girdle pains, crises, no muscular wasting, no R.D. nor real paresis.)

(2) *Injury or disease of lower part of cord* (cord terminates at lower border of L_1; asymmetry of symptoms in favour of cauda equina.)

(3) *Extra-spinal diseases and injuries to the nerves of the lower limbs* (such as multiple neuritis.)

Thorburn concludes that injuries to the cauda equina are the only traumatic lesions in which trephining the spine is justifiable and likely to be serviceable, and not even then in every case.

Or (B) A System Disease. Such (*in the widest* sense of the term) are—

(1) Primary lateral sclerosis.
(2) Progressive muscular atrophy and Acute atrophic paralysis (infantile).
(3) Amyotrophic lateral sclerosis = (1) + (2).
(4) Tabes (posterior sclerosis, etc.).
(5) Ataxic paraplegia = (4) + (1) [Pellagra = (5) + (2)].
(6) Friedreich's hereditary ataxy = roughly (5) + (4).
(7) Syringomyelus (cavitation of grey matter, with gliosis of immediately adjacent white).
(8) Hæmatomyelus (ploughing up of grey matter by effused blood).
(9) Morvan's disease = (7) + peripheral neuritis.

Multiple lesions such as—

(i) Disseminated sclerosis
(ii) G.P.I.
(iii) Chronic hypertrophic meningitis
(iv) Multiple tumours especially syphilomata,

are worth mentioning.

A *Pathological* diagnosis may be based upon the onset.

Rapid and sudden onset = Vascular lesions, ruptures, or lacerations of the cord.

Acute onset } = Acute and subacute inflammation.
Subacute onset }

Chronic onset = Degenerations, growths, gradual compression from any cause.

The symmetrical character of the increased tendon-jerks rather suggested a spinal lesion, but if so it must have been high up in the cervical region. On the other hand, no interference with any reflex function could be found, or local evidence of a lesion here. The progress was too acute for any degeneration, but it might conceivably have been a case of early compression from (say) syphilitic deposit in the meninges of the cord very high up.

A. J. S.

Notes from South Africa.

Sandal-wood Oil Rash.

I place this case on record as being one of interest, and the more so as neither Crocker nor Fagge mention oleum santali specifically as being an eruption-causing drug. The well known copaiba rashes, however, readily suggest themselves in this connection.

The patient was a man æt. 28, who had gonorrhœa for four weeks. Nineteen days before admission he began taking capsules. These were contained in a bottle labelled "Santal Midy" (Midy, Paris), and each held ɱv. of ol. santali. He took six in a day for three days, and then noticed "spots" on his face. They next appeared on his arms and subsequently on his chest and legs. He stopped taking the capsules a week ago, but took two the day before admission.

His face was very thickly covered with papules, the little intervening skin presenting an erythematous blush. In some parts there were vesicles, approaching bullæ in size here and there. The neck was also covered, and the chest, face, forearms and hands less abundantly.

On abdomen and back there were only one or two scattered papules. On lower part of both legs and feet there were papules fairly abundantly distributed. Temperature normal.

He stated that he noticed the vesicles only a few days back. He still had slight urethral discharge, but no chancre.

In hospital, the eruption rapidly disappeared, some of the bullæ becoming hæmorrhagic before clearing away. No treatment was adopted but the exclusion of the drug.

Spina Bifida. Perforating Ulcer of Foot.—A boy æt. 5, came up with a meningocele in the common position in the lower lumbar region. It was about the size of a cocoanut, was translucent and had no bands running across it. There was a deep cylindrical ulcer on the right heel and another shallower one on the ball of the same foot. Both ulcers were very foul. The bladder

was emptied involuntarily at intervals. Motion and sensation were unimpaired. He had no glycosuria

With rest in bed, and boracic dressings, the ulcers all but completely healed, but no treatment directed to the meningocele was allowed; and the case is recorded merely to call attention to an occasional complication of spina bifida.

Note.—Some weeks after the boy was brought to out-patients with the ulcers again becoming troublesome owing to neglect.

Fir-cone Seed in Trachea. Tracheotomy.—A girl æt. 8, the day before admission swallowed a fir-cone seed, shell and all. It was the seed of *pinus maritima*, a kind that children often crack and eat here. The child had a severe fit of choking and coughing on swallowing the seed, and ever since has had attacks of a similar nature from time to time, and distress in breathing between. She did not sleep at all during the night, and next evening was brought here.

She was breathing rapidly, though not actually dyspnœic, presenting more an expression of apprehension, and saying that she can feel the seed, pointing to the position of the trachea. There are numerous râles over both lungs.

Tracheotomy was performed under $CHCl_3$, a long incision being made in the trachea. The seed was then seen bobbing up and down with each respiration and expiration. It was seized with forceps and removed. A considerable quantity of mucus was ejected through the wound, the foreign body having set up severe bronchitis. The skin was sutured, leaving, however, a central aperture in case of accident.

Bronchitis proved very troublesome the first night, and for two or three days after, but then subsided. The wound healed rapidly.

New Somerset Hospital, Cape Town. C. C. ELLIOTT.

Reviews.

A Hand-book of Diseases of the Eye and their Treatment. By Henry R. Swanzy, A.M., M.B. Edited under supervision of the author, by Louis Werner, M.B. (H. K. Lewis, London, 1895). Price 10s. 6d.

The popularity of Dr. Swanzy's well-known hand-book of diseases of the eye is evidenced by the fact that it has reached a fifth edition. In the preparation of this volume, the author has had the able assistance of Dr. Louis Werner, who has evidently devoted much time and thought to making the book as complete as possible. The work has been thoroughly revised, and some new material has been added. Amongst other new features there is a full description of Jarval's astigmometer, by the aid of which both the degree of astigmatism and the position of the meridians of greatest and least refraction can be accurately and rapidly determined. The book can be warmly recommended to all who are engaged in eye work.

The Year Book of Treatment for 1895; a Critical Review for Practitioners of Medicine and Surgery (Cassell & Co., London, 1895). Price 7s. 6d.

This valuable year book has reached its eleventh year, and the volume before us fully keeps up the well deserved reputation of its predecessors. It is unfortunate that the section on bacteriology has had to be admitted, but the other sections are fully up to date, and in most cases contain summaries of the recent work on the subjects treated, which are well worthy of careful attention. The articles on General Surgery by Dr. Rose; on Diseases of the Heart and Circulation, by Dr. Coupland; on Medical Diseases of Children, by Dr. Dawson Williams; and on Surgical Diseases of Children, by Mr. Owen, may be mentioned as being specially interesting and valuable. By no means the least valuable part of the book is the selected list of new books, new editions and translations, with which the volume closes.

A Text Book of Physiology. By M. Foster, M.A., M.D., L.L.D., F.R.S. Sixth edition. Part I. (London, Macmillan and Co.).

Although only recently received by the library committee, this, the first part (comprising Book I.), was published in 1893. It deals with blood, the tissues of movement, and the vascular mechanism. The volume chiefly differs from the corresponding portion of the fifth edition in the section devoted to the consideration of the vascular mechanism. In this part considerable changes have been rendered necessary owing to the more exact knowledge of the subject which the work of Hurthle has rendered possible.

Helps in Sickness and to Health; Where to go and what to do. By Henry C. Burdett. (London, the Scientific Press). Price 5s.

Probably few men have devoted as much time and attention to the subject of hospitals as has the author of "Hospitals and Asylums of the World." As might be expected, therefore, the portion of the book dealing with the subject of "Where to go in times of Sickness," is full of most valuable information, and will be of the greatest help to all those who have occasion to send patients to hospitals. For this part of the volume we have nothing but praise. With regard to the other parts, namely, those dealing with health, and the treatment and nursing of emergencies and simple ailments, the author seems to us at times unnecessarily dogmatic, and by no means always correct. Further, the condensation which has been necessary, to force so large an amount of information into so small a space, has in many cases led, almost unavoidably, to obscurity in the directions given rather than to clearness. On the whole, however, it may be safely said, that, whoever buys this volume will, at some time or other, feel grateful to the author for giving him, in an easily accessible form, information which is often by no means easy to obtain.

Sport.

Association Football.

SURREY CUP TIE.

EWELL v. GUY'S.

This match, after several postponements on account of the frost, was played at Ewell on Saturday, March 2nd. The ground was in a shocking condition—one of the spectators likened it to a dung-heap—and in the opinion of both teams totally unfit for a Cup Tie; unfortunately the decision on this point rested, not with the players, but with the referee, who was quite positive that the game ought to come off. The game started a little after the advertised time, before an enthusiastic crowd of spectators, ten of whom hailed from Guy's, the shouts of the latter for the Hospital being well seconded by a fair number of the locals. Fitz-Hugh, having lost the toss, kicked off down the mountain-side, but the Ewell men immediately got possession, and to the surprise of all kicked a goal in the first minute, while the Guy's backs looked admiringly on. Ten minutes later one of the Hospital halves, forgetting for which side he was playing, further increased Ewell's lead with a magnificent shot. From "hands" in front of goal they scored again, the game at this point standing 3 to 0 in favour of Ewell. The Guy's forwards now thought they might as well try to take the ball somewhere near the other goal, and as the result of some fast and vigorous play, managed to pierce the International defence, when Stamford successfully sent the ball into the net off his ——, well, not exactly his head. For the rest of the first half the Hospital men kept up a strong attack, and shortly before half-time scored again through Mandy, though several good opportunities were lost through erratic shooting, Fitz-Hugh and Stamford being chief offenders in this respect. The interval arrived with the score, Ewell 3, Guy's 2.

On restarting, it was soon evident that Guy's, playing uphill, would have all their work cut out, not only to win, but to keep their opponents from increasing their lead. This they managed to do for the first twenty minutes, but afterwards Ewell had matters all their own way, and scored three times. The backs evidently thought Lavers was quite capable of looking after himself and the ball as well, for they certainly made no effort to protect him from the rushes of opposing forwards. The Hospital front rank made a few spasmodic efforts, which died away in front of goal, chiefly because none of the halves, except Crosby, gave them any assistance. On time being called, we had to acknowledge defeat by no less than 6 goals to 2. This, however, was not a very bad performance under the circumstances, as our back division was thoroughly disorganized, owing to illness and injuries. At the last moment Walker was taken from half to play back, which position he has not filled before, while Longhurst played for the second time this season. Carter and Lidderdale were greatly missed, and Goadby, who has for some time filled the latter's place with success, was also on the injured list. Walker played well at times in his new position, but he, in common with the rest of the team, were far too gentle with their opponents—a charge which is not often made against medical students. The pick of the team were Mandy, Crosby and Lavers. Mandy worked hard, and was always a thorn in the side of the Internationals. Crosby gave a fine exhibition of half-back play, the best this season, but he was overtaxed at times in having to mark two men. Lavers played a very fine game in goal, and brought off some really marvellous saves, for which he gained much applause. We have, however, seen him play better, but on this occasion he was not so confident as with the usual more reliable backs. In conclusion, we would impress upon the committee the necessity for strengthening the back division (both half and full) for the Hospital Ties. Team:—

N. Lavers (goal); E. A. Longhurst, F. E. Walker (backs); A. E. Crosby, E. J. Crew, M. H. Thornley (half-backs); P. S. Mandy, W. G. Palmer, R. T. Fitz-Hugh, R. B. Stamford, L. Humphrey (forwards).

United Hospitals' Hare-and-Hounds.

THE race for the United Hospitals' Challenge Cup took place at Chingford on Saturday, March 2nd, over a ten-mile course, consisting of two circuits of five miles each.

Two hospitals competed—Guy's (holders) and Bartholomew's—the first three home in each team being counted.

Munro, of course, ran splendidly, and held the lead the whole way, finally defeating Mundy by 3 minutes 40 seconds.

The victory of Guy's was mainly due to the very plucky running of P. F. Henry, who was in good form, and would not be denied third place, although Wilde did his best to catch him.

	5 Miles.	10 Miles.
1. Munro (Guy's)	30·48 ...	62·35
2. Mundy (Bartholomew's)	31·18 ...	66·15
3. Henry (Guy's)	31·48 ...	67·25
4. Wilde (Bartholomew's) ...	32·30 ...	68·37
5. Mason (Bartholomew's) ...	32·20 ...	69·25
6. Balderston (Guy's)	33·20 ...	70·27
7. Hay (Bartholomew's) ...	—— ...	——

Guy's thus won by one point.

Guy's ... ... (1+3+6)=10.
Bartholomew's ... (2+4+5)=11.

Guy's have now held the Cup for four years (in succession), Bartholomew's and Thomas's twice each, and Mary's once. B.

Death.

CHAMPNEYS.—On February 11th, suddenly, at Hamilton House, Penge, Henry Montagu Champneys, F.R.C.S. Eng., in his 77th year.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied with the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual subscription to the GAZETTE *is 6/6, post free 7/6. All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING *and* SIXPENCE.

Guy's Hospital Gazette.

MARCH 23, 1895.

Metrorrhagia.

CLINICAL LECTURE BY DR. GALABIN.

WE have now in Dorcas ward two cases, illustrating metrorrhagia occurring at the menopause.

They are of practical importance, as the occurrence of hæmorrhage at or near this time may be due to cancer. Further, there is an idea abroad that this condition is not at all a dangerous one; so that sufferers often do not seek early advice. So that, in cases where there is no evident cause for the hæmorrhage at or after this period, you should urgently advise a local examination to find out whether the cause be cancer or not.

After the menopause is completely passed, unless there is some local cause, such as prolapse, the hæmorrhage is generally due to cancer.

Near the time of the menopause the cause is most frequently something other than cancer, but it is safer to make a local examination in these cases also, in order to detect the tenth case that may be due to cancer.

But there are various other causes of metrorrhagia at this as at other times of life.

Cancer of cervix originates chiefly—

(1.) From proliferation of epithelium of glands.

(2.) From ingrowth of columnar processes from the deeper layers of the squamous epithelium of the cervix.

The cervix is generally examined by means of touch, speculum, and microscope.

In the latter process a small piece of the tissue of the cervix is removed with a sharp spoon, this is then hardened, and sections are cut and examined to make out its histological characters, which furnishes us with a most valuable proof, as to whether the tumour is malignant or not.

If no sufficient cause for the hæmorrhage is found in the cervix, we must proceed to examine the uterus both by sound and bi-manually.

Profuse hæmorrhage on passing of sound would cause suspicion of cancer.

Then the condition of the internal surface of the uterus can be made out with the sound, that is, whether there are irregularities or inequalities of the surface.

If the irregularities are very marked it indicates cancer. On making a bi-manual examination we can make out whether the fundus uteri is enlarged and whether there are any masses attached to the outer surface; these symptoms, if present, indicate the probability of a *fibroid tumour*.

A fibroid tumour consists of the normal uterine tissues in varying proportions, and they may so grow as to form a uniform swelling of the uterus, or they may be squeezed out by the action of the muscle so as to form swellings on the outer surface of the uterus.

When the tumour is squeezed inwards so as to become completely extruded on the internal surface so that it is only attached by a pedicle, it is called a *polypus*, which may be intra-uterine or projecting through the os.

The latter may be recognised by finger and speculum, the former by feeling after the dilatation of the cervix uteri, when they are felt as soft pedunculated masses. The dilatation must be carried on until the finger can be introduced to the top of the uterus. The polypi growing from cervix can be recognised by digital examination without dilatation.

Mucous polypi may also cause metrorrhagia, though more commonly only leucorrhœa. These

consist of several mucous follicles with a stroma of soft and delicate connective tissue, the stroma predominating over the glandular portion.

These are most commonly growing from the canal of cervix, when they may be detected by digital examination or with speculum. When they are in the uterus the cervix must be first dilated as before.

Carcinoma of fundus also causes hæmorrhage, and its diagnostic signs, distinguishing it from fibroid tumour, have been mentioned above. A small piece may be taken out by a curette and examined under the microscope, if its character is at all doubtful.

A piece of *retained ovum* may sometimes be the cause of metrorrhagia.

Lastly, we have as a cause *fungoid endometritis*. This is the result of chronic inflammation, but leads to a condition resembling rather growth than inflammation, involving proliferation both of glands and interglandular stroma. These glands become dilated irregularly, and are filled with rounded cells instead of being lined for the greater part of their course with uniform cylindrical epithelium.

By the irregular proliferation of these glandular cells, villous prominences are produced, the superficial layers of the mucous membrane becoming quite loose, so that they are freely moveable on the deeper layers, and may eventually be thrown off.

In structure it very much resembles an adenoma; so that Bland Sutton has suggested that we should call it adenoma, but I think that the term is not a good one, as the name adenoma suggests a definite well-marked tumour; but we may, however, call it adenomatous hypertrophy of mucous membrane.

This also affects the cervix uteri and often extends to that part of the cervix lined by squamous epithelium. In this case it can be seen with speculum as an irregular granular surface of red appearance.

It is often accompanied by leucorrhœa.

In making the diagnosis in these cases, the first step is to dilate the cervix, and this is best done with Hegar's dilators.

When a considerable amount of dilatation is required, it is advisable to introduce a laminaria tent on the preceding day of the examination or operation. By this means a No. 20 Hegar can be introduced, which often could not be done without the previous use of tents, except by causing considerable laceration.

When the cervix has been thus dilated, the inside of the uterus may be scraped out.

This may be done either with a Sim's curette (which has a sharp cutting edge), or with a Thomas' blunt curette.

The advantage of the latter is that less mischief can be done if the instrument is used by an inexperienced person.

But in the cervix uteri the sharp curette had better always be used, as the part is more difficult to scrape out, owing to the interglandular stroma having a more fibrous character than that of the fundus.

Then iodized phenol may be applied to the scraped surface by means of a probe.

Another caustic that is sometimes used is nitric acid, but this is generally applied without previous curetting.

The former treatment is the better of the two.

There are two great classes of inflammation of cervix:—

(1.) Those due to catarrhal inflammation of the lining mucous membrane. In these the parenchyma of the cervix becomes only moderately swollen, and ultimately indurated.

(2.) Those in which the whole thickness of the cervix becomes inflamed from the injuries received in parturition. In these, extensive induration eventually occurs, and cervical endometritis at the same time persists.

The first class comprises most of the cases which occur in virgins and nulliparous women.

If any of the conditions above numerated as causing metrorrhagia are present, the result is aggravated by the above condition of the cervix.

The most important of the injuries caused by labour is lacerations of cervix. When these are superficial they often heal. But if there is a deep laceration at each side, the anterior and posterior lips of the cervix roll outwards, so as to evert the lining mucous membrane. The delicate mucous membrane being thus exposed to friction becomes inflamed, swollen and deeply injected, and its surface granular from irregular proliferation of stroma, so that it closely resembles the surface of an erosion or granular inflammation, at a place originally covered by squamous epithelium.

A laceration on one side only may also lead to some degree of eversion of mucous membrane with granular inflammation.

If there is only one laceration, it is generally on the left side, because the occiput of the child is generally directed in that way, and so causes greater strain at this point.

In simple erosion, the epithelium and papillæ are detached, leaving a surface which is much less granular than in the case of laceration and eversion.

All these morbid conditions aggravate menorrhagia and metrorrhagia by keeping up irritation.

The pain accompanying cervical inflammation is generally in the lower part of the back over the sacrum.

But a more constant symptom than pain is leucorrhœa, and this morbid secretion may be the only indication for investigating the condition of the uterus.

Since cancer of cervix is excessively rare in virgins, commoner in parous than in nulliparous women, and still commoner in those who have had many children, it appears certain that erosion or other form of inflammation may be the starting point of cancer in persons predisposed to that disease.

This is further supported by the fact that the histological characters of some villous erosions resemble very much that of commencing cancer, and I have seen epithelioma supervene upon chronic granular inflammation.

In treating these cases it is very important to look after the general condition of the patient, as well as treating it locally.

The two chief operations for the cure of this condition are :—

(1.) Emmet's trachelorraphy ; and

(2.) Schrœder's operation.

In performing the first operation a Sim's speculum with a short blade, or that variety of it known as Simon's speculum, should be introduced, and then the edges of the cervix pulled down with tenaculum forceps, so that the operation can be performed immediately behind the vulva, instead of deep down in the vagina.

The edges of the laceration should then be pared, and sutures should be introduced in order to draw together the pared edges.

The sutures are best introduced by means of a Hagedorn needle holder, which requires special kind of needles.

If there is another laceration, that is treated in the same way.

In the second operation, a wedge is cut out from the centre of one or both lips, removing the hypertrophied glandular tissue, which, in long-standing cases, may prevent the sides being approximated without too great tension. Then the raw surfaces are brought together by means of sutures.

In some cases I have been able to combine the two together.

In other cases when you want to perform the two operations you must perform them successively, as you might cut the sutures of your first operation in doing your second, if they are both performed at one time.

Case I.—M. A. C., æt. 46. First admitted in September, 1894. Patient has one child living, and had one miscarriage ten years before admission. She complains of having "lost" continually during the last twelve months.

Periods very irregular and painful, from the age of 15—when periods commenced—to 30, when she married.

On admission.—Had a slight discharge of a dirty brown colour. Her trouble commenced about twelve months before admission, when she lost continually for eight weeks, then she remained free for about a fortnight, when she began to lose again, and lost continually until April, 1894, when she ceased losing for eight weeks. Patient had had a feeling of tightness and dragging across the abdomen. During the last month she has had only a slight dirty-looking discharge. Patient says that her abdomen at times was swollen considerably. At times she has difficulty in micturition. Patient's general condition was treated for some time.

On October 5th she was examined under anæsthetic. The cervix was found patulous, admitting index-finger through external os. Old laceration of external os on both sides, but deeper on left. A band of induration could be felt in the broad ligament on each side running from the lacerations. Uterus was bulky, not freely moveable. Sound passed three and three-quarter inches from tip of anterior lip.

There was bleeding on the use of the sound, but not excessive. Irregularity could be felt at top of fundus by rotating tip of sound.

Os was dilated to No. 20 Hegar's dilators. No ulceration could be made out on digital exploration.

The uterus was then scraped out with sharp and blunt spoons, and touched with iodized phenol.

Patient was discharged on October 15th.

Patient was re-admitted for recurrence of same complaint on January 31st, 1895. Patient was quite well as far as the "losing" was concerned for two months after discharge from the Hospital. At the end of that time patient "lost" for four or five days. She "lost" again a month after this, and continued "losing" for three weeks. It stopped finally about a fortnight before admission. The discharge was foul-smelling. Patient has had shooting pain in her stomach and back.

On examination with speculum, the anterior lip of cervix was found everted and covered with a villous erosion which bled on touching.

February 4th. Schrœder's operation was performed, the vagina being washed out with 1·4000 perchloride twice a day.

15th. Stitches taken out.

March 8th. Tracheloraphy was performed on left side of cervix, five sutures being used.

18th. Patient has just had a period. Loss not excessive. Stitches were taken out; the wound had quite healed and was looking well.

Case II.—A. M., æt. 46, has nine children alive, and has had six miscarriages. Admitted on February 25th, 1895, for continuous loss of blood since last September, and passing a quantity of lumps, and having pain in back. She has lost flesh since October. Her grandmother, her mother, and aunt (on mother's side) all died of cancer. She has always had a pale discharge after periods, but since October it has become more profuse and watery and very bad smelling.

Vagina full of dark bloody discharge. Cervix split, but segments not thickened. No growth to be felt; edges of segment a bit nodular. External os admitted finger half-inch. There was some hæmorrhage on vaginal examination. The discharge was not foul enough to prove malignancy.

March 4th. Patient was examined under anæsthetic. Bleeding seemed to come from cervix in part, but some also through cervical canal. A sound passed four and a half inches, and uterus felt rough inside cervix; was dilated up to No. 16 Hegar's. No ulceration or growth could be felt by little finger passed its full length into uterus, but fundus was not quite reached.

With the scoop some pieces of tissue were removed which looked rather like hypertrophied mucous membrane. Then some masses fully a quarter of an inch in diameter came away, and were thought at the time to be malignant. No caustic was therefore used until this had been tested by microscope.

The uterus and vagina were then washed out with Hyd. Perchlor., and an Iodoform suppository introduced to vagina.

On microscopical examination of the masses, the structure was found to be that of adenoma. The gland cavities were proliferating and dilated, but lined by regular epithelium; and there was abundant embryonic-looking stroma between.

Since the operation the patient has had a recurrence of profuse hæmorrhage. This may be only menstrual. If it persists, it will be necessary to dilate more fully, curette more completely, and apply a caustic afterwards. There is still the possibility that the adenomatous hypertrophy may go on to malignancy.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	9, 16, 19. Mitral regurgitation.
	23. Mitral stenosis and regurgitation. Aortic regurgitation.
	41. Mitral stenosis.
Philip	1, 39. Aortic regurgitation.
	24. Ulcerative endocarditis.
Stephen	6. Mitral and tricuspid regurgitation. Aortic stenosis.
	16. Ulcerative endocarditis.

Nervous System.

Mary	6. Chorea.
	26. Optic atrophy.
	47. Chorea.
Philip	11. Right hemiplegia. Aphasia.
	32. Aphasia.
	36. Syphilitic myelitis.
Stephen	5. Ataxic paraplegia.
	11. Cerebellar tumour. Optic atrophy.
	28. Exophthalmic goître. Glycosuria.
	30. Locomotor ataxy. Diphtheria.
	34. Cerebral tumour. Optic atrophy.
	38. Myelitis.

Alimentary System and Abdomen.

Mary	1, 43, 44. Gastric ulcer.
	7. Perityphlitis.
	9. Typhoid fever.
Philip	22. Perityphlitis.
	33. Carcinoma of stomach.

Genito-Urinary System.

Mary	2. Hydatid of kidney.
	10. Diabetes mellitus.
Philip	6. Chronic nephritis.
	10, 14. Diabetes mellitus.
Stephen	18, 3, 17. Acute nephritis.
	19. Diabetes mellitus.
	23. Chronic interstitial nephritis.

Respiratory System.

Mary	18, 30, 50. Phthisis.
	22. Bronchitis. Cyanosis. Ascites.
	29. Pneumonia.
	32. Broncho-pneumonia.
	35. Pneumothorax.

Philip	17.	Pleurisy. Influenza.
	20, 35.	Bronchitis.
	26.	Fibroid lung. Bronchiectasis.
	28.	Broncho-pneumonia. Influenza.
	38.	Phthisis.
Stephen	13.	Empyema. Phthisis.
	31.	Syphilitic laryngitis.
	33.	Pneumothorax.
	37.	Phthisis.

Miscellaneous.

Mary	3.	Acute rheumatism.
	14.	Chronic ulcers of leg.
Philip	3.	Osteo-arthritis.
	4.	Gonorrhœal rheumatism.
Stephen	24.	Acute rheumatism.
	11.	? Tertiary syphilide. ? Psoriaris.

Influenza.

Mary	25.	

Cases under Dr. Pye-Smith.

Philip.

Ulcerative Endocarditis. Mitral Obstruction and Regurgitation.

21. W. G., æt. 15. Admitted February 19th for pains all over the body, general weakness, wasting and anæmia.

Family history.—Good.

Previous history.—Patient had no illness till he was eleven years old. He then caught a chill, and was laid up for six months with "rheumatism and heart disease." He suffered with aching pains, which occurred at times in all parts of his body, there was no special pain or tenderness in the joints; the symptoms came on slowly, and got gradually better. Eighteen months ago he had a second attack, which presented the same characteristics and lasted about the same time.

Present illness.—This commenced five months ago, with pains similar to those above mentioned, aching, not shooting in character, and usually remaining a whole day or more in the same locality. Three months ago patient began to waste rapidly, and for the last two months he has been confined to his bed, being too weak to stand. One month ago he was taken worse, and was not expected to live; he had acute pain in the cardiac region and dyspnœa; these, however, went off and he rallied again. Since then he has had profuse sweating, which occurs chiefly at night; he has not had any rigors. A week ago the pain settled in the abdomen, and patient became worse and lost his appetite. A day or two before admission the right leg was flexed at the knee with pain at the back of the joint, but this condition passed off.

On admission.—Temperature 103·6; pulse 112; respiration 28. Patient is much wasted and appears weak and exhausted. He is intensely anæmic.

Circulatory system.—Impulse diffused, but felt behind nipple in fourth space. There is systolic retraction of third and fifth spaces. A short systolic thrill can be felt. Cardiac dulness normal. There is a loud harsh systolic, and a rumbling diastolic bruit at the apex. The systolic murmur can be heard at the angle of the scapula, and over most of the front of the chest. Pulse regular, medium sized, very compressible, dicrotic. Blood corpuscles 70 per cent.; hæmoglobin 45 per cent.; platelets conspicuous. Fingers not clubbed. No œdema of ankles. No retinal hæmorrhages.

Respiratory system normal.

Alimentary system.—Tongue, not furred, tremulous. Spleen enlarged and tender. There is pain across the abdomen at the level of the umbilicus, but no tenderness on palpation. Appetite bad. Bowels very constipated.

Progress of case.—Patient's general condition has not altered much since admission. His temperature shows a marked diurnal rise and fall, ranging from between 103 and 104 at midnight, to between 97 and 100 at mid-day. On February 23rd the acute pain in the abdomen returned, and has continued, with some intermissions since. On February 26th, and again on February 28th, there was vomiting. No blood in vomit. On February 27th patient complained of pain in his right leg, and it was found that no pulse could be felt in the dorsalis pedis. On March 4th he had another sudden attack of pain and could not straighten his leg at the knee; pulsation was found to be absent from the posterior tibial. The bruits have remained constant and in position, but have varied very much in loudness from day to day, and they have been observed to alter considerably after a violent fit of coughing.

26. H. A., æt. 18. Admitted for cough, with pain in left side of chest, on February 15th. No family history of phthisis. At 12, patient had pleurisy on left side, since when he has always had cough, with expectoration of large quantities of muco-pus. Two months ago patient brought up about three ounces of blood. A month later patient was seized with pain in left side, and occasional rigors. His cough became worse, and he began to spit up some "brick-coloured" sputum. Was very dyspnœic. Temperature was taken and found to be 102 degrees. Remained in bed at home for a month, but did not improve.

Condition on admission.—Patient is thin and anæmic, and has pain and tenderness in upper part of left chest. Pulse, 100; respiration, 40; temperature, 98.

Respiratory system.—Chest is very prominent on right side, the right ribs being bulged forward at costo-chondral junctions, while the left slope away straight from sternum. The right side moves much more freely than the left. Behind, the right side is more bulging than left. T.V.F. most marked in right axilla.

On Percussion.—Right side resonant all over. Left side, in front there is "skodaic resonance" at apex; behind there is dulness from base up to eighth rib.

Auscultation.—On right side the breath sounds are harsh and loud all over, and expiratory murmur as loud

as inspiratory. On left side, loud gurgling râles and sonorous rhonchi which completely obscure the breath-sounds. *Bronchophony* at left side.

Sputum.—Very abundant and muco-purulent. No tubercle bacilli.

Heart.—Impulse is diffused, being visible in third, fourth and fifth spaces, most marked in last, in nipple line; dulness normal; sounds normal.

Urine normal.

18th. Bronchitis has cleared up and breath sounds on left side can be heard, but are very faint. Loud gurgling râles all over left chest.

20th. Patient's temperature rose to 103·8, since when it has varied continually between 103 and normal.

23rd. Loud tubular breathing to be heard over seventh rib in posterior axillary line, and also more faintly heard down to tenth rib behind. Loud bronchophony and also pectoriloquy.

27th. Dulness is more marked behind, and now extends up to spine of scapula. Breath sounds loudest at apex in front. Tubular breathing heard all over axilla, and from fifth rib down to base behind. Loud crackling râles to be heard over same area.

March 5th. Patient in about same condition, but breath has become fœtid.

Dr. Pye-Smith thinks that the diagnosis lies between chronic interstitial fibroid changes with dilated tubes, or phthisis commencing at left base; probably the former.

Case under Dr. Goodhart.

Mary.

Chronic Tubal Nephritis—Pregnancy—Abortion.

23. Patient, æt. 32, was admitted on January 31st for swelling of face, abdomen and legs.

Personal history.—Patient is a married woman, has had six children; no miscarriage. At present time she is four months pregnant.

Previous illnesses.—Patient was a remarkably healthy woman until six and a half years ago, at which time she was pregnant with her fourth child. This illness consisted of swelling of the face, abdomen and legs. Swelling disappeared after delivery. Before the births of her fifth and sixth children, she was troubled with swelling of legs and abdomen. Patient noticed that the urine on these occasions was high-coloured, and micturition was somewhat painful. There has been no swelling of limbs, etc., at times other than those of pregnancy. She has never had fits.

Present illness.—Patient noticed that the veins of lower extremities were becoming distended about three months ago. On January 25th, her legs became swollen, especially the right. The hands were also swollen. On January 26th, face and abdomen were swollen. Since January 24th, patient has suffered from sickness and vomiting. Micturition has not been frequent. Urine is scanty and irritating. No twitchings of muscles.

On admission.—Temperature 98; pulse 87; respiration 18. The face is swollen, especially under the eyes; hands slightly swollen; no œdema of chest wall; abdomen distended with fluid; the lower extremities are œdematous and veins are varicose.

Urinary system.—Micturition not frequent; urine scanty, of dirty-brown colour; reaction, acid, sp. gr. 1026: contains albumin 11 parts per 1000; amount passed in 24 hours = 36 ounces; blood is present and epithelial casts and cells.

Alimentary system.—Appetite is poor; patient vomits milk soon after taking it; bowels are regular; the abdomen is distended with ascitic fluid; the uterus can be felt extending upwards and midway between pubes and umbilicus.

Circulatory system.—Pulse is slow, regular and of low tension.

Heart.—Normal cardiac dulness; at the apex the first sound is accentuated and rather long; sounds normal at base.

Nervous system.—Normal; no retinitis.

Treatment.—Milk; barley water; Imperial drink.

℞ Pulv. Jalapæ Co. ʒss. h. n.

℞ Pot. Cit. ʒss.

Mist. Ammon. Acet. ʒi. 4 hrs.

February 8th.—Œdema of face and legs disappeared. Blood not present in urine. Albumin, same as on admission. Patient often vomits after taking milk. Abdomen measured 41½ inches at umbilicus.

23rd.—The legs were very swollen. Pus appeared in urine three days ago. Abdomen measured 43½ inches at umbilicus. Œdema of abdominal wall very marked. Some dulness and diminished breath sounds at both bases of lungs behind.

Since the patient came in, the urine has remained the same, except that the epithelial cells and blood have disappeared. The quantity passed in twenty-four hours has varied between 12 and 40 ounces. The sp. gr. between 1020–1034. The minimum amount of albumin recorded is 8·5 parts per 1000 and maximum 11 parts per 1000. Urea has varied between 1·3 per cent. and 2 per cent.

On February 1st, Dr. Goodhart saw the case, and thought that, after watching the patient for some time, it would be advisable to procure abortion. The patient did not improve under treatment, and Dr. Shaw asked Dr. Horrocks to see the case.

On March 1st, Dr. Horrocks saw the case and decided to procure abortion. The cervix was dilated by means of a bag, and after the lapse of 24 hours the patient was delivered of a fœtus.

15th. Urine, 52 ounces; sp. gr. 1010; acid, albumin 2·5 parts per 1,000; urea 5 per cent. Patient was put on full diet on March 5th, milk on March 9th, and the urine improved from that date. The œdema of the legs decreased steadily. Abdomen measured 38 inches at umbilicus. Patient went out of her own accord on March 16th.

In the Surgical Wards.

Cases under Mr. Howse.

Accident 5. Hæmatoma in thigh.
7. Sub-pericranial hæmatoma of skull.
23. Compound fracture of tibia.
31. Numerous stabs with penknife in abdominal wall; not penetrating.
Cot. Sub-aponeurotic hæmatoma of skull.
Charity 6. Periostitis of radius and ulna. ? Syphilitic.
7. Carcinoma recti.
8. Strangulated femoral hernia.
16. Mammary abscess: incision. Scirrhus of breast.
Cot. Imperforate anus.

Cases under Mr. Davies-Colley.

Cornelius 10. Acute infective periostitis of tibia following blow on leg; ankle joint contains pus; incisions in leg and into ankle joint; knee swollen.
Lydia Cot. Prolapse of rectum.
Luke 1. Old pulpy disease of knee. Leg flexed, abducted and rotated out.
6. Tubercular metacarpus.
11. Stricture. Retention of urine.
13. Hip joint disease. Stricture of urethra.
14. Mastoid abscess. Thrombosis of lateral sinus. Rigors. Antrectomy. Lateral sinus incised. Internal jugular ligatured. Patient doing well.
15. Talipes equinus. Over extension of great toe.
21. Genu valgum.

Cases under Mr. Lucas.

Lydia 10. Large double iliac abscess; incisions; bare bone felt about lumbo-sacral spine.
20. Lupus being treated with thyroid extract.
Job 5. Otorrhœa. Pain in head.
18. Cured spina bifida. Talipes. Boy of eight.
19. Irreducible femoral hernia.

Cases under Mr. Golding-Bird.

Martha 1. Ununited fracture of clavicle; fragments wired.
4. Necrosis of coccyx.
5. Scirrhus mammæ.
6. Scirrhus mammæ.
8. ? Callus on rib, following fall; very painful.
18. Left femoral hernia; irreducible.
Cot. Hare lip.
Lazarus 8. Tubercular knee following rheumatic synovitis (acute rheumatic fever).
10. Fistula in ano.
Lazarus 11. Recurrent sarcoma in groin. Large fungating mass of small, round-celled sarcoma removed last year.
13. Anal abscess.
14. Tubercular testis. Suppurating inguinal glands.

Cases under Mr. Jacobson.

Dorcas Cot. Strumous dactylitis.
Patience 15. Strumous dactylitis in woman of 52. Suppuration of bursa patella.

Cases under Mr. Symonds.

Martha 14. Ectopia vesicæ. Plastic operation.
Patience 3. Child of 10 weeks with gangrene of scrotum.

Cases under Mr. Lane.

Dorcas 4. Ankylosis of jaw, knee and elbow. Girl of 18.
15. Appendicitis. Recurrent.

Case under Mr. Dunn.

Martha 11. Central sarcoma of lower jaw; excision of lower jaw.

Case under Mr. Howse.

Naaman.

18. M. P., æt. 33, dock labourer. Admitted March 16th for pustule on face, and for enlarged glands in neck. Patient has been carrying skins at the docks for thirteen years; last carried skins a fortnight before admission. On the 11th, he noticed a pimple upon his right cheek, and his cervical glands began to enlarge at the same time. He came up to the surgery on Friday, 15th, but insisted on going home for a short time before he came into the Hospital. His temperature then was 104·4. There was a small pustule, the size of a pea, upon his right zygoma, with indistinct vesication around it. There was slight œdema of the face and neck.

16th. *Condition on admission.*—Patient is a finely-built man. The pustule is more distinct, and vesicles have formed. There is œdema on the right side of the chest as far as the nipple, on the right side of the neck and face. The glands in the neck on the right side are uniformly enlarged, resistant, and do not fluctuate. Temperature 104·8. Pulse 118.

1.30 p.m. *Operation.*—The pustule was removed, and lunar caustic applied to stop the bleeding. The cavity was packed with ipecacuanha and dressed with carbolic gauze. Five injections of carbolic (1–20) of about seven minims each were made into the neck over the enlarged glands.

6 p.m. Patient has come round. He is violent and delirious. Temperature 103·8; pulse 120; respiration 32.

17th. Patient died at 4.30 this morning. Half an hour before death his temperature rose to 105.4.

Autopsy.—The glottis and epiglottis were œdematous. The lungs were congested, and there was a subpleural

hæmorrhage upon the right side. The spleen was soft. In the stomach there were hæmorrhagic erosions and ecchymoses. Four or five hæmorrhagic patches were found in the large, and twelve to fourteen in the small intestine. The meninges were intensely congested, and there was some extravasation of blood. The cerebral vessels were enlarged. A preparation from the spleen showed the anthrax bacillus.

Some Cases of Injury or Disease of the Knee-joint.

During the past month there have been in the Hospital a very interesting set of cases illustrating many phases of injury and disease of the knee-joint. They make so complete a clinical picture that I propose to abstract their reports and compare them.

Case I.—S. L., æt. 46. A vigorous, powerful man. On February 6th, while carrying a sack of potatoes, he slipped on a sheet of ice in the gutter, and fell, striking his knee on the ground; he was then unable to walk.

On admission.—He was found to have a transverse fracture of patella, with a separation of the breadth of a finger between the fragments.

On February 8th Mr. Golding-Bird opened the joint by a semilunar incision, convex downwards, surrounding the patella. The fragments were brought together with one silver wire, which was left *in situ*. A carpenter's gimlet, which is far more serviceable than the customary bradawl, was used for boring the patella. The wound healed by primary intention.

Case II.—J. B., æt. 13. A slight lad. On February 12th, a horse that he was backing almost trod upon his foot, and in jumping back to avoid it, he fell. Patient says that he felt his "knee snap."

On admission.—There was no bruising of the knee, but the patella was fractured transversely, with slight separation of the fragments. This boy was treated in the same way as the last case, and has made as good a recovery.

Case III.—A. H., æt. 18. A dark, well-developed girl. The patient says that her right knee has been weak for some time past, and that she has felt creaking in it. On February 13th she was stooping in "the squatting position" to pick up a brush, and as she rose up she felt "something snap in the right knee." She was afterwards unable to stand. In half-an-hour her knee had swollen to a great size, and was very painful.

On admission, on February 19th, the right knee-joint is full of fluid, which feels denser than serum. There is no inflammation, and but little tenderness. As the swelling subsided a moveable body was felt on the inner side of the knee at the level of the semilunar cartilage.

On February 26th, the joint was opened by an incision extending from the level of the adductor tubercle and sweeping round the patella to a point over the tubercle of the tibia. The loose body proved to be a densely-thickened patch of the synovial membrane, and the joint was full of dark blood at a high tension. The moveable body was removed, and the joint having been washed out, the synovial membrane was sewn up with silk.

Case IV.—W. J., æt. 29. A butcher. A slight delicate-looking man. On January 16th, patient was admitted for ankylosis of left knee. Nine months ago he had a definite attack of rheumatism, which "settled in" his left knee-joint, which had to be subsequently straightened with a splint. Three months later he was in under Dr. Goodhart, who made a diagnosis of pulpy disease, and leg was put on a splint, then a few weeks ago he saw Mr. Lane, who deferred operation owing to the inflammation in the joint.

On admission.—The left knee is rounded in appearance, and the hollows obliterated, the skin is smooth and glossy, there is no inflammation, the limb is considerably wasted, and there is absolute ankylosis in the extended position. The joint was gradually flexed by the aid of a McIntyre splint and some inflammation supervened. A few days later it was forcibly moved, under an anæsthetic, which set up an acute inflammation which subsided under treatment. A week later it was again forcibly manipulated; but there was only slight pain in movement.

February 25th. The knee is swollen by a thickening of the synovial membrane, and by a dense fluid within the joint. Patient complains of starting pain, and of spasmodic flexion when he is moving about. The man has lost a stone in weight since his admission. Mr. Golding-Bird is of opinion that the condition is one of pulpy disease, and proposes to excise the joint.

Case V.—K. M., æt. 20. A well-nourished, dark-haired young woman. Mother's leg was amputated for disease of the knee-joint, soon after which she died. The personal history is unimportant.

On February 19th she was admitted into Martha for a painful swelling of right knee. Three years ago her right knee became swollen and painful, and for two years remained "weak" and troublesome. About a year ago the swelling increased, and she suffered much pain at night. At the beginning of the present month the pain became more severe, both by night and day, with increased swelling of the joint. She has been under constant treatment, but without benefit. The disease has not incapacitated her from work.

On admission.—The knee-joint is swollen, but the skin normal in appearance; there is slight thickening of the synovial membrane, with considerable effusion into the joint. On the outer side of the knee, over the semilunar cartilage, there is a tender spot when a crackling sensation is felt. The movement of the joint is limited to flexion to a right angle. There is no wasting of the limb.

Operation on March 1st.—The knee was opened as in Case III. The synovial fringes were thickened on the outer side of knee, presenting somewhat the appearance of a mass of small chorionic villi; the cavity of the joint was distended by a thin gelatinous substance; there was no involvement of bones or cartilage. Mr. Golding-Bird scraped away the synovial membrane, and having thoroughly washed it out, closed the joint.

Case VI.—S. P., æt. 17. A slightly-made youth. The patient's father is a chronic rheumatic. About five

years ago the left knee enlarged, probably from synovitis; the limb wasted rapidly at first, but it has not altered much during the last two years. Exercise or a slight blow increases the swelling.

On admission.—The skin over knee is normal in appearance; the limb is much wasted. On manipulation the knee is found to be full of thin fluid, the bone margins of the orbicular surface are slightly enlarged and bossy, and there is a feeling of irregular thickening in the synovial membrane on the inner aspect of the joint. Flexion beyond a right angle is impossible. No creaking in the joint could be distinguished.

Operation.—An incision, as in Case III., was made, and a thickened mass of synoval membrane with enlarged fringes was removed, the remainder of the membrane was found to be much thickened, and the lipping of the articular margins, above noted, was compressed.

Case VII.—E. T., æt. 33. This case was admitted into Charity under Mr. Lucas, on February 18th, with a very markedly rheumatic family history, and eleven years ago she was in Guy's with rheumatic fever. Seven months ago patient fell, bruising her right knee, since that time every now and then her knee "catches," and "seems to come out and go in quick," causing her acute pain.

On admission.—There is slight synovitis with some impairment of movement. A hard tender moveable lump is felt just above and in front of the head of the fibula.

At the operation this was found to be a small nodule of thickened synovial membrane becoming cartilaginous, the knee was otherwise healthy.

Case VIII.—K. S., æt. 42. Admitted on January 28th, under Mr. Davies-Colley, into Lydia. On November 5th, 1894, patient fell over a step and injured her knee, it was then treated with Jacob's oil and other embrocations; as she remained helpless she sought advice at Guy's, and was found to have a fractured patella with an inch separation.

Operation.—The patella having been exposed by a median vertical incision, was found to be feebly united by fibrous bands; these having been cleared away, and the bone surfaces freshened, the fragments were wired together. Following the operation there was some superficial suppuration, but subsequently wound healed up without damage to joint.

Case IX.—M. P., æt. 21. An anæmic young woman under Mr. Lucas' care in Lydia. In 1893 an operation was performed to correct ankylosis, in a flexed position, of the hip. At this time the tibia was almost dislocated backwards from the femur, owing to the pull of the hamstrings on the flexed knee.

On February 19th, she was admitted with the knee in a helplessly flail-like condition on account of the alteration of the position of the opposing surfaces of the joint caused by the straightening of the leg, and the consequent laxity of the ligaments in the new position. Mr. Lucas excised the knee-joint.

Cases I., II. and VIII. make a complete picture of fractured patella in "man, woman and child," and Case VIII. demonstrates the helpless condition of a limb after this accident without surgical interference.

Case IV. is, perhaps, the most interesting of the whole series, owing to the confusion of diagnosis caused by the man's very intelligent history of acute rheumatism, after which ankylosis, though rare, is known to occur. The subsequent behaviour of the joint to the usual remedies demonstrated clearly that some other condition must be present, for, instead of a rapid give-in movement by manipulation, the joint remained very stiff, and became permanently swollen, while the limb continued to waste until at the present time it presents the typical appearance of a "pulpy joint" in an early stage of the disease.

Cases III. and VII. may be compared, in both of which there was several months' history of "weakness," and in which the same condition of a small, thickened patch of synovial membrane was found. In III. a confident diagnosis of loose body was made, and in VII. from the history, a more guarded one, of loose cartilage.

Cases V. and VI. are typical cases of rheumatoid-arthritis occurring in one joint in young people. The youth has a rheumatic inheritance, but of the girl no such inheritance can be traced. Removing the diseased membrane is found to diminish the frequency of the attacks of arthritis and pain, of which both these patients complained.

The operation in every case was conducted under strict antiseptic precautions, and almost all of them made an uninterrupted recovery. V. P.

Nursing News.

We are pleased to hear that the Treasurer has sanctioned the following extension of annual holidays, suggested by the Matron, for the Probationers and Nurses:—

First year, two weeks.
Second year, three weeks.
Third and following years, four weeks.

It is with much regret that we have to mention the loss, on March 1st, of Miss Hutton's services as Sister of Accident ward, but our sincere good wishes go with her to the new sphere she is shortly to enter.

Miss Metcalf entered on her duties as Sister of Accident ward, on March 8th. We give her a hearty welcome.

List of those who have passed the Materia Medica, Pharmacy and Dispensing Examination, February, 1895:—

1. Lawrence	10. Hobhouse	19. Ogilvie
2. Anson	11. Traill	20. Yeaxlee
3. Skerman	12. Leng	21. Morrah
4. Pooley	13. Healy	22. Coupland
5. Homfray	14. Mansel	23. Davis
6. Powell	15. Woods	24. Drewry
7. Goodall	16. Stowell	25. Lushington
8. Woodward	17. Fox	
9. Goode	18. Clarke, S.	

On the Zambesi in a Gunboat.

On the Zambesi River and its tributary, the Shiré, on the East Coast of Africa, are to be found two British gunboats—the "Mosquito" and the "Herald." These vessels were placed on the river four years ago, and their duty is to patrol the river and keep it open for traffic, which, before their arrival, was carried on under great difficulty, both on account of the high-handed proceedings on the part of the Portuguese and everlasting squabbles among the native chiefs. The territory on both banks of the Zambesi as far as it is navigable has belonged to the Portuguese for the last 300 years, but the river is of importance to Great Britain, being the only highway to British Central Africa, namely, the Shiré Highlands and Nyasa land. The trade on the Zambesi is all in one direction; there is a vast quantity of material proceeding *up* the river, but for the last two years all that has come *down* from all this country to the north were a few bags of coffee which were sent down from the Shiré Highlands.

It must be remembered that the Zambesi district is the abode of the dreaded tse tse fly, and that consequently no baggage animal can exist, and that all stores, where no river is available, have to be carried on the heads of native porters in loads of 50 pounds or less.

The construction of these two gunboats is somewhat peculiar. They are built in sections of thin steel plates. Each section was sent out separately and then put together on the banks of the river. The length of each vessel is 78 feet, and breadth 18 feet. The boiler is in the bow, and the propulsion obtained by a large wheel at the stern—the bottom of the vessel being flat, and the draught of water two feet. This type is essentially for river service, and is unable to take the sea.

The crew consists of one lieutenant, one surgeon, 18 bluejackets, 9 Zanzibaris, and 15 natives. The term of service for the Europeans being nominally a year—that is to say, one wet and one dry season.

Some idea of the malarial nature of the station may be gathered from the fact that no European served 12 months without an attack of malarial fever or dysentery, and by far the majority had several attacks—the usual type of fever being that known as "bilious remittent."

The Zanzibaris, who are half-caste Arabs, also suffered from fever, but to a less extent, and whether the natives of the country suffer from malaria is a doubtful question.

A malignant type of malarial fever known as hæmoglobinuric, or "black water fever," caused the death of two bluejackets and seven European residents during the months of July and August, 1893–94.

The months of June, July and August are considered the most unhealthy months of the year. This is thought to be due to the drying-up of the vast tract of country flooded during the rainy season. As the swollen river subsides, the water of the swamps is drained off, the muddy deposit rapidly dries in the sun, and the whole country is soon covered with a dense growth of rank grass six to ten feet high.

As the dry season proceeds this grass gets burnt up by the sun and is fired by the natives, the resulting grass fires lasting for weeks and making travelling on foot once more practicable. For about seven months in the year it is impossible to get about the country on account of the grass and swamps, and it is only for four or five months that it is possible to shoot game. Another reason being that, when water is plentiful, the game leaves the banks of the river and wander about to other districts.

The fertility of the soil is remarkable—this being no doubt due to the alluvial deposit, as is the case in the valley of the Nile.

Rice, maize, Egyptian corn, etc., grow luxuriantly, but the natives, especially those under Portuguese rule, are a lazy and improvident race. The surface of the soil is scratched with a hoe and sown, generally by women, the work being done in a most careless manner; and no fence being erected the crops are exposed to the attacks of hippopotami, antelope, and pigs. Tomatoes, sweet potatoes, pumpkins, tobacco, Indian hemp, and castor oil are generally found growing half wild near the villages, the oil of the last named being much prized but only as an article of toilet. The principal food of the natives is maize and a flour made from pounded grain, and boiled till it forms a thick doughy mass. It is from pounded grain also that they make their intoxicating drink called *pombé*, a kind of beer of the consistence of gruel, sweet and effervescent at first, but becoming quite sour after fermenting a day or so.

Higher up country on the Shiré river the natives are of a better type, being of Zulu descent, and are capable of hard work and endurance on a very small food allowance. A porter will carry on his head a load of fifty pounds a distance of 28 miles, ascending 2,300 feet, his food consisting of three "corn-cobs" (*i.e.*, heads of maize or Indian corn) per diem, washed down with water; his wages for the round trip being a yard or two of calico.

Meat is not often obtained by the natives themselves, but they will eat it voraciously whenever they get the chance, especially if it be a hippopotamus or an eland—these two animals being the only two that have any fat on their bodies, and a native will barter anything for "fat meat."

Whenever a hippopotamus is shot the natives swoop down upon it like a flock of vultures. Amidst a fearful din the carcass is dragged to the bank and ripped up. The paunch (considered the great delicacy) is first secured by the most able-bodied man in the crowd, or, as often as not, torn to shreds in the struggle. Other adventurous spirits force their way in and scramble for the fat around the kidneys. Every man plies his weapon, whether axe, knife, or spear, with great vigor, and with a total disregard to his neighbour, and then staggers off with his load of meat. Soon nothing remains of the huge beast, not a bone or a strip of hide being left behind to tell the tale. On arrival at the village, large

pots full of meat are put on the fire, but this is generally demolished before it is half cooked, and then with howling, clapping of hands, and dancing and drumming, they pass away the time till another brew is ready, and so they go on all night, alternately gorging themselves and dancing, and the amount of meat consumed at each sitting is awful to contemplate.

After an "all-night sitting" of this kind, the revellers are seen lying around the empty flesh-pots, semi-comatose and highly distended as to the abdomen. In two or three days they will be about again as usual, and perhaps will not taste meat for months afterwards; but whenever they do get a chance at flesh of any sort the boa constrictor is simply not in it with the African.

SURGEON J. DOWSON, R.N.

(To be continued.)

The Scientific Diagnosis of Nervous Disease.

IV.

"For my part, I approve of paying attention to everything relating to the art, and that those things which can be done well or properly, should all be done properly . . . ."—Hippocrates, *The Management of Acute Diseases*, § 2.

D. Intracranial lesions. Superfluous as it seems to say so, it is absurd and foolish to attempt to diagnose cerebral disease without having at least some vague idea of cerebral anatomy and physiology. Amongst other examples the writer would refer to that of a University man, whose ideals (as stated by himself) were lofty, but were never carried into practice. When, as ward clerk, his duties required him to report a nervous case, he would act as follows. (1) Test the knee-jerks; (2) Inquire for syphilis; (3) Get *Gowers* (both volumes) out of the library for a week; (4) Complain that before he could get the faintest conception as to what Gowers was talking about, he must expend at least two hours' hard study on *Quain* and *Foster* (which of course he never did spend).

General Symptoms of Intracranial Disease.

1. Optic Neuritis. (Advice to those about to buy an ophthalmoscope; get one with a rotatable *oblique* mirror such as "Paxton's," and don't be satisfied till you can *see* with it. Cost 35s.)
2. Vertigo.
3. Vomiting (a boy recently in Philip would eat half his egg, vomit, and immediately proceed with the other half).
4. Headache.
5. Coma.
6. Psychical disorder or defect [such as delirium, loss of memory, delusions, moral perversion, etc. Alienists have long been aware that a man's morals and disposition, in part at any rate, depend upon his heart and arteries. *E.g.* the Bishop who was found in a brothel. The patient with heart-disease at Bethlem, who looked uneasy "as if something were going to happen." As Dr. Wilks predicted, *something did happen*, for the aneurysm (or whatever it was) burst about ten minutes later. See also *Regina v. Hallsay*, C.C.C. Sessions, January, 1895, and *Daily Telegraph*, January 8, 1895].

(*The above have no localizing value whatever*).

7. Conjugate deviation of the eyes and head.
8. Convulsions, especially if commencing locally, proceeding by a definite march and accompanied by little or no disorder of consciousness (= Jacksonian epilepsy).
9. Paralysis, such as Hemiplegia, or paralysis of any cranial nerve.

(7, 8, and 9 *may have considerable localizing value.*)

The lesion may be—

(1) At the surface of the brain, *i.e.*, either

α. At the base. It is to be remembered that there are a dozen brace of cranial nerves touring about in this region, and with any macroscopic lesion here the chances are that some of them will get let in for something.

β. At some part of the hemispherical cortex. (Macalister, I regret to say, does not give the millimetric area of cortex available, but at any rate it is $5\frac{1}{4}$ times what it would be if the surface of the hemispheres were smooth).

γ. At the surface of the cerebellum. Or

(2) In the substance of the brain or cerebellum; or

(3) Inside the ventricular cavities of the brain.

More is known about the motor functions of the brain than any other, so the simplest plan is to trace up the motor tracts and ascertain whether the symptoms could be produced by a lesion at each successive level.

A. Medulla. A lesion confined to this locality may affect either or both Motor Tracts. The upper part of the face usually escapes. If at the surface, some of the following nerves will be involved (often symmetrically)—VII., VIII., IX., X., XI., XII. (Soemerring).

A good example of such a lesion would be chronic syphilitic meningitis (see case lectured on by Dr. Hale White, and reported in *Clinical Journal*, February 7th, 1894). If in the substance of the Medulla some of the nuclei of the above nerves will be implicated, that of the VIth also being frequently involved. The nuclei are mostly so close to the middle line that bilateral palsy is almost invariable (sooner or later). With such a lesion the chances are that the motor tracts will escape. With serious lesions in both of the above situations, muscular wasting will eventually occur.

The best example of the latter lesion is Simple Progressive Bulbar Paralysis (= Polio-*encephalitis*, just as Progressive Muscular Atrophy = Polio-*myelitis* chronica—and it is an interesting fact that many cases of Progressive Muscular Atrophy and, what is much the same

thing, Amyotrophic Lateral Sclerosis terminate by invasion of the bulbar nuclei).

[*Pseudo-bulbar paralysis* occurs from bilateral (therefore excessively rare) lesions of the cortical centres for the bulbar nerves. The lesion is supranuclear, and hence there is no amyotrophy].

B. Pons. A lesion here may affect either or both motor tracts. If at the surface the chances are that one or other of the following nerves will be caught—

V. (= Anæsthesia of face, conjunctiva, mouth, etc., and paresis of masticatory muscles, including Buccinator,)

VI. (= External rectus.)

VII. (The orbicularis palpebrarum is affected as well as the orbicularis oris.)

Conjugate Deviation of the eyes and head may occur:—

(1) towards the *paralysed limbs* with a *paralytic* lesion:

(2) towards the *lesion* in the brain with a *convulsive* lesion.

Unilateral lesions of the Pons produce—

In its lower half.—Alternate hemiplegia with well-marked facial palsy on the opposite side to the paralysed limbs.

In its upper half.—Ordinary Hemiplegia with well-marked facial palsy on the same side as the paralysed limbs.

An example of such a lesion would be a small spot of softening set up by arterial degeneration.

A large central lesion in the Pons may give rise to profound coma, flapping respiration, contracted pupils. If the fatal event is delayed for a few hours, hyperpyrexia (reaching 109° or 110°) is not at all uncommon shortly after an acute lesion such as hæmorrhage.

The following comparison of lesions in the Pons and Medulla is taken from Dr. Bastian (*Paralyses, Cerebral, Bulbar and Spinal*, p. 375):—

Deglutition and articulation impaired in both.

Pons.		Medulla.
Well-marked, including the orbic. palp. and may be either the same or the opposite side to the hemiplegia.	Facial paralysis VII.	Confined to lower part of face—and often bilateral.
Normal	Phonation, Palate, Pharynx, IX., X., XI., Impaired.	
Impaired, hence sensory defects in face and paralysed limbs and strabismus from paralysis or irritation of VI.	Vth and VIth nerves	Usually unaffected.
May be Normal.	Cardiac and Respiratory centres in Medulla	Interfered with.

C. Corpora quadrigemina. Nothing sufficiently certain is known as to lesions here from a diagnostic point of view.

D. Crura. A Lesion of the *inner and inferior* part of one crus, produces paralyses of the IIIrd nerve on the same, but hemiplegia (including tongue and face) on the opposite side to the lesion. If, however, the lesion be limited to the *upper and outer* part of the crus, then the IIIrd nerve may escape entirely, and the hemiplegia be indistinguishable from that due to a capsular lesion. In lesions of the crus sensory impairment is usually well-marked in the paralysed limbs, which also may show conspicuous vaso-motor disturbance (Gowers).

E. Primary nuclear degeneration of the nuclei of the IIIrd, IVth and VIth nerves in the floor of the *Aqueduct* is well recognised and has been termed *Polio-encephalitis superior*, the parallel disease of the bulb being *Polio-encephalitis inferior* (= Bulbar Paralysis). The only known cause is syphilis, and the palsy usually becomes bilateral, or affects one side and then the other.

F. Lesions of the corpus striatum and optic thalamus gain their importance from implication of the fibres passing through the posterior limb of the internal capsule which separates them. The order of the fibres in the posterior limb is (from before backwards).

Anterior two-thirds { Face and Speech. / Arm. / Leg.

Posterior third { "Sensory crossway" of Charcot, including the special senses and all forms of sensation.

Lesions of the anterior two-thirds practically always depend upon lesions (hæmorrhage, embolism, thrombosis, aneurysm, endarteritis, softening, etc.) of the lenticulo-striate artery, supplying the outer part of the lenticular nucleus (= 'the artery of unenviable reputation.').

The posterior extremity of the thalamus has an independent blood-supply from the posterior optic branch of the posterior cerebral artery. A lesion here is recognised by implication of the contiguous fibres in the sensory crossway. A good many cases of post-hemiplegic "chorea" and athetosis have been found to depend on a lesion here. Hence, according to the extent of the lesion, we may get, either Hemiplegia of the usual cerebral type; or, the anterior fibres (*i.e.*, articulation, tongue, lips, and face) may escape; or, on the other hand, if the lesion extends far back we shall get complete Hemianæsthesia for *all forms of common and special sensation* (the most important of the latter is *Homonymous Hemianopia, i.e.*, with right hemiplegia the patient is unable to see things in the right half of the visual field of each eye). "There may be deviation of head and eyes at the onset, but no permanent and complete palsy of any cranial nerve." Complete hemianæsthesia may be due to *functional* disease, as in a case which recently came under the writer's notice. Here there was no real hemiplegia or facial paralysis, but a great deal of tremor of the left arm and leg. The visual defect was, almost complete blindness of the field of the left eye, with concentric

reduction of that of the right (= crossed amblyopia, the visual field most affected being on the opposite [left] side to the functional disorder of the cortex [on the right side]).

G. CORPUS CALLOSUM. Nothing certain is known as to lesions limited to this region.

H. CORTEX OF HEMISPHERES. The symptoms depend upon the "centres" involved (see Ferrier, *Functions of the Brain*). The most valuable of all for diagnostic purposes are definite Jacksonian fits preceded by an aura, commencing locally, proceeding by a definite march, and when accompanied by disorder of consciousness *this* feature occurs *last* and *least*. Partial lesions will produce various forms of *monoplegia, i.e.*, palsy or convulsion of one or other limb, or of the face and arm whilst the leg escapes. Conjugate deviation of the head and eyes to one side, has, if present, *some* localizing value. The rule is that the patient looks towards the side of the *convulsion* when this exists (to see what *is* happening), but towards the *lesion* in the brain when there is *paralysis* and no convulsion (to see what *has* happened—upstairs). This is just the reverse of what obtains in pontine lesions. (For explanation see Ross, Taylor, etc.) Under cortical disorders *Epilepsy* and *Hystero-epilepsy* must not be forgotten.

I. SUBCORTICAL REGION (Centrum ovale). Lesions here according to their exact situation will more or less closely simulate

α. Cortical.

β. Capsular lesions.

Localized fits only occur when the lesion is immediately below the surface. *Aphasia* (if it occurs) is transient. *Anæsthesia* is not usually well-marked unless the lesion is very extensive and involves the posterior extremity of the Internal Capsule.

J. INTRAVENTRICULAR LESIONS—such as (*a*) hæmorrhage, bursting through the brain substance, or (*b*) "serous apoplexy" consequent on cicatricial or other obstruction to the outflow of fluid through the aqueduct and foramen of Majendie). If extensive may produce profound coma.

(1) If one lateral ventricle be distended the whole cortex of that side will have to be compressed against the skull before well-marked localizing symptoms are produced.

(2) When the effusion extends backwards so as to distend the IIIrd and IVth ventricles the centres in the floor of the IVth ventricle may be compressed, producing slow pulse, laboured stertorous respiration, subnormal temperature, glycosuria and vasomotor disturbances. General convulsions may occur followed by pyrexia, râles, lividity, etc., within even two hours from the onset of the lesion.

K. CEREBELLUM.

α. Middle lobe. Lesions here produce general and increasing paresis without definite hemiplegia. Reeling gait (but absence of Romberg symptom so characteristic of *Tabes*), nystagmus, retracted head and neck and tetanus like rigidity. In a third of the recorded cases sexual excitement has been noticed. There is no sensory disorder whatever. Knee-jerks may be absent.

β. Lateral lobes. Incomplete paralysis of the opposite arm and leg has been frequently noticed, more marked in the leg and generally absent from the face. A tendency to fall over to the side of the lesion in walking has also been noticed.

Hemianæsthesia occurs under three conditions.

(1) Functional disorder (of the cortex?).

(2) Lesions of posterior extremity of Internal Capsule. In both the above all forms of sensation are usually involved.

(3) "Mesocephalic" lesions of the crus or pons. In this case smell and sight are not involved, and taste and hearing may also escape.

Visual disorder occurs in three leading forms.

(1) *Homonymous hemianopia, i.e.*, blindness of one (say the right) half of each visual field (= *left* half of each retina). This may be due to a unilateral lesion situated in:—

(*a.*) Optic tract (left).

(*b.*) Optic thalamus (left).

(*c.*) Posterior extremity of internal capsule (left).

(*d.*) Anywhere in the course of the fibres from (*c*) to (*e*).

(*e.*) Apex of occipital lobe (left).

(2) *Crossed Amblyopia.* In a well-marked case there is complete blindness (or complete with the exception of the fixation point) of the visual field of one eye (say right), with concentric reduction of the other (the left). [See diagrams in *Gowers* or other works.] Amblyopia of this nature is very frequently associated with colour-defects (dyschromatopsia) following the same lines as the defects for common objects. It has till lately been pretty generally believed that this form of visual and colour-defect is invariably associated with either

α. *Cortical disease* (of angular and supra-marginal gyri, in this case on the left side); or

β. *Cortical disorder* (of a functional or "hysterical" nature). And much stress has been laid by the French school on this concentric reduction associated with colour-defect as reliable evidence of "hysteria." Dr. Buzzard however, at the B.M.A. meeting at Newcastle in 1893, brought to light the facts that typical concentric reduction with dyschromatopsia may be

present in *Tabes* and *Insular Sclerosis*, especially with what he has called the "hysterical" type of insular sclerosis. It is of course quite possible that the disorder is of a functional nature, but superposed on the organic disease, in fact this is rather probable as the blindness is often only temporary.

(3) *Central scotoma* of one or both visual fields, frequently accompanied by central colour-defects. This appears to be due to an axial optic neuritis and is due to toxic causes (tobacco or alcohol).

Nystagmus occurs in—

a. Insular sclerosis.
b. Friedreich's hereditary ataxy.
c. Chronic alcoholism.
d. Cerebellar disease.

Tremor occurs under numerous conditions, an excellent account and classification of which will be found in Pietersen's article *Tremor* in Tuke's *Dict. Psychological Med.*, vol. ii., p. 1320.

On examining the case previously reported it will be seen that it did not present a single positive symptom of definite cerebral disease, localisable or non-localisable. Supposing we had found evidence of definite cerebral disease, and (more or less) accurately localised it, the next step would have been the Pathological Diagnosis, which depends mainly on the rapidity of onset of the symptoms. A list is given here for convenience of reference (compiled from Bastian).

Onset rapid (arranged roughly in order of rapidity).

1. Traumatism (more remote results = cerebritis; meningitis; abscess; tumour; disseminated sclerosis; G.P.I.)

Vascular lesions.

2. Embolism (much commoner under than over 40).
3. Thrombosis of arteries or sinuses (if complete succeeded, like 2, in a few days by inflammatory softening).
4. Hæmorrhage (meningeal—commonest age 31–40, intracerebral, or cerebellar—commonest age 61—70).

Gintrac's statistics of 637 post-mortem cases of hæmorrhage are so instructive that I make no apology for quoting them.

Meningeal	172
Middle lobes	127
Pons and Crura	76
Corpora striata	72
Cerebellum	55
Cortex of hemispheres	45
Optic thalami	38
Posterior lobes	33
Anterior lobes	17
Medulla	2
	637

5. Acute meningitis.

Onset Gradual.

6. Tumours of brain* and meninges (including tumours of the pituitary body with or without symptoms of acromegaly, and exostoses of the skull).
7. Abscess.
8. Chronic localised Meningo-Encephalitis (due to syphilis, traumatism, or tubercle).
9. Disseminated Sclerosis, and General Paralysis.
10. Aneurysms (the large ones keep to the larger vessels, the miliary ones to the tiny vessels; with cardio-vascular disease they may occur at any age, those in youth being the result of preceding embolism, usually septic. No definite symptoms are usually produced till rupture occurs, which in the majority of cases produces meningeal rather than intracerebral hæmorrhage).
11. Simple cysts, Hydatids and Cysticerci.
12. Birth-palsies.

A. J. S.

[Erratum in Article III., p. 96, column 1, line 13 from foot, *for* pyramidal tracts *read* grey matter (?); line 10 from foot, *for* grey matter (?) *read* pyramidal tracts].

Theobromine-sodio-salicylate (Diuretin) as a Diuretic.

This drug has recently been so much lauded as an infallible diuretic in cardiac dropsy and chronic nephritis, that I have thought the following two cases, in which it has been given, may prove of interest. The diuretic action of the substance, as will be seen, was in these two instances *nil*.

Case 1.—J. F., æt. 12, was admitted for chronic tubal nephritis of one and three-quarter year's duration. There was slight general œdema and high tension pulse; the urine contained albumin, 9 parts per 1000, no blood; the amount was about 50 ounces per diem. Soon after admission the quantity of urine greatly diminished, and for some days averaged only 5 ounces. Diuretin was given in doses of 8 grains t.d.s., and increased up to 12 grains four times a day. No increased flow of urine followed, the average quantity for the ten days from the commencement of the administration of diuretin remaining at 5 ounces.

Case 2.—C. H., æt. 30. Chronic interstitial nephritis. For some days only a few ounces of urine were passed. Injections of pilocarpine caused profuse diaphoresis, but failed to relieve uræmic symptoms; diuretin, 20 grains 4tis horis, was ordered, but had no effect in increasing the urinary flow. The patient died of uræmia.

L. A. PARRY.

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* The first symptom of tumour may be the fatal hæmorrhage into it.

Case of Oxalic Acid Poisoning.

Cases of oxalic acid poisoning are not uncommon, but probably the following notes of a death from that cause may be of interest to your readers.

G. B., æt. 27, a French-polisher, was last seen alive about 4.30 p.m., when he went down to the lavatory on the ground floor of his workshop, which floor was used as a lumber room as well. The next morning, about 9, he was found sitting on a half-made couch, about ten or twelve feet from the lavatory, in an easy attitude, with one knee raised and resting against the back of another couch in front of him, over which he must have climbed to get where he was. I was called to him and found him as stated; there was no sign of any convulsive action, the fingers of the hands, which were resting on the lap, being drawn in merely and not clenched; the face had a calm appearance, the body was quite cold and rigor mortis complete; there was nothing to show that he had vomited. On removing the body to the mortuary some yellowish brown mucus ran from the mouth. Face pale, as also the lips, there being no appearance of any caustic action on them. No one about him had any idea of an intention to commit suicide, being a good workman in full employ and busy preparing for getting married shortly. His tea-can, in which he told his boy that he had mixed some oxalic acid (used in their work) when he wanted to fetch his tea, was found in the lavatory.

I made the post-mortem 72 hours after he was last seen alive, and the following are the notes taken at the time:—

No marks of any external injury.

Rigor mortis still marked except the neck.

Body that of a muscular, well-nourished man.

Tongue swollen somewhat and having a white soddened appearance.

Œsophagus had a similarly bleached look.

Stomach contained about five to six ounces of a dark brown glairy fluid, having no particular smell, and a small quantity of partially digested food.

The mucous membrane at the cardiac end was much swollen and softened, with a reddish patch posteriorly. The rest of the surface was grey, the smaller vessels being mapped out in black lines, having a stellated interlacing appearance. Dark brown mucus stains in lines along the length of the stomach. No abrasion for corrosion.

Heart arrested in diastole, healthy; blood quite fluid, of a dark lake colour, no clotting anywhere.

Brain.—Vessels congested, containing dark fluid blood.

The rest of the body was that of a healthy man.

The contents of the stomach were strongly acid, effervescing freely with Bicarbonate of Soda, even when diluted with three or four times its bulk of distilled water. After diluting with distilled water and filtering, the filtrate gave with a solution of Silver Nitrate, a dense white precipitate soluble in cold Nitric Acid, a solution of Chloride of Calcium, a white precipitate insoluble in Acetic Acid, even when added in excess, but soluble both in Hydrochloric and Nitric Acids.

J. J. U.

The Smoking Concert.

The last "Smoker" of the Season, held on Saturday, March 9th, drew a good house to appreciate the fare provided for its amusement through the energy of Mr. R. H. Fagge, who was himself, to everyone's regret, unable to occupy the chair—a post which Mr. Slater kindly filled. Mr. Dunn was present during the earlier part of the evening.

Proceedings began with a pianoforte solo, "La Czarine," by Mr. Munro, and up to the finish everything went with spirit. Mr. B. F. Pendred's song, "Were I the Streamlet" was well received, though we thought it a pity he could not trust himself to an accompanist. Mr. Michael sang "It ain't all Lavender," which was followed by "All through a dear little Lady" as a well-deserved encore. Later, he (as *she*) and Mr. Robinson introduced the popular duet, "Naming the Baby," which proved highly diverting, and caused the "Music Halls" duet from "Morocco Bound" to be given as encore. Mr. Robinson also sang earlier in the programme "To Althea from Prison," and "I would I were a King" (encore). Mr. Aspinall, whose songs were so appreciated at a previous smoker, sang "Whatever wind may blow," "Last Night" (encore), "Eileen Carew," and told a couple of anecdotes in conclusion. Mr. Fortescue-Brickdale played Handel's "Largo" and other selections on the violin in his best style, while Mr. Cockell's sweet tenor voice was heard to advantage in "Ailsa Mine," "A Spring Song" (encore), and "Mary of Argyle." Mr. Lulham's sketches never fail to give amusement—this time we were favoured with the "May Week" sketch, and with a portion of the well-known "Restaurant" scene.

"Tommy Atkins" never went better than when led by Mr. Young, who was also responsible for "Three Trusty Friends," and "My Lady's Bower." We doubt if even the original "Judge" was as funny as Mr. Allport made him on Saturday night. Mr. Allport, in his time, "plays many parts." We remember to have seen him as "the whining school-boy," as the lover "sighing like furnace," and then the "justice in fair round belly," etc., in fact, there seems no end to his eccentricities, and we really do not know which most amuses and excites to wonder.

Owing to indisposition, we lost vocal contributions from Messrs. T. L. Jackson and W. Whishaw, who were unable to sing.

Messrs. Hardenberg and Lidderdale shared the duties of accompanist, and after "Auld Lang Syne" and the National Anthem, hearty cheers were accorded Mr. Fagge for the enjoyable concert which had been arranged by him.

Joseph Parsons

Was born at Stamford, Lincolnshire, in 1837, and at an early age came up to the metropolis, where he was apprenticed to a saddler, in Willow Walk, Bermondsey. He learnt his trade, and in 1857, enlisted in the 4th Light Dragoons, now the 4th Hussars, which regiment had just returned from the Crimea, so decimated after Balaclava, that Parsons joined as No. 34. After ten years spent at home stations, Parsons left York with the regiment for India in 1867, and was stationed at Meerut and Rawal Pindi. While no opportunities for active service of a serious order presented themselves, the 4th did a lot of frontier work, and, previously to the last

Afghan Campaign, were engaged in a survey of the route to Candahar, evidently a most arduous undertaking, and this preliminary march to Candahar must have paved the way for the historic achievement of General Roberts' force. Holding the rank of Corporal Saddler, Parsons generally had a busy time, especially during the frontier expeditions. He also formed one of the escort to the Prince of Wales during his visit to the North Western Provinces. Twenty-one years of service completed, he returned home in 1878 with the good conduct medal, and shortly afterwards, he obtained the post of Porter at the back Lodge of the Hospital, from whence he was promoted to the front. Six years ago, he caught scarlet fever, but remaining at his post too long without medical treatment, his health became permanently affected, and, latterly, has been so shattered as to necessitate the voluntary tendering of his resignation, which, we have reason to believe, the authorities accepted, with every regret at losing a staunch and courteous servant.

"I had never known what it was to be ill before," said Parsons, in the course of a little chat the other day, "why, I remember when I was 14 years old running away from my apprenticeship to go to Stamford Fair. I found myself in the afternoon at London Bridge with five-pence in my pocket. Here a shepherd's dog joined me, and we walked on to Ware, which we reached at 9 p.m. I asked the way to Cambridge, but took the wrong road, and at 2 a.m. found myself in Ware again, having done a circle; but making a fresh start immediately, the dog and I walked into Cambridge, where we arrived next forenoon, having done the journey from London on a penny loaf between us. An ostler at Cambridge was kind to us, and we rested that day, and the next saw us at Wansford, 45 miles further on our road, and only five miles from Stamford, where we arrived the day following. I found my friends, and thoroughly enjoyed the Fair. My master sent a severe reprimand, but he accompanied it with a suit of clothes and the money to bring me back. I had five pounds given me for the dog, on the promise that the money should be returned if the animal was claimed."

Parsons told us other interesting incidents which space will not enable us to record; but he said—"there is one thing I would like to do, if you put anything in the Gazette about me, and that is, to thank all past and present students for their kindness, and to hope that they have never found me wanting."

We heartily wish Parsons a sufficient restoration to health and strength to enjoy his well-earned rest at Midhurst.

The reproduction of Parson's photograph is from one kindly taken for us by Mr. E. E. Henderson.

Appointments.

Bevan, Richard, L.R.C.P. Lond., M.R.C.S. Eng., D.P.H., has been re-appointed Medical Officer of Health for Lydd.

Roberts, C. Gordon, M.B., B.C. Camb., has been re-appointed Medical Officer to the Halstead Urban Sanitary District.

Worts, Edwin, L.R.C.P. Lond., M.R.C.S. Eng., has been re-appointed Surgeon to the Essex and Colchester General Hospital.

Stephens, Lockart, M.R.C.S., L.R.C.P., has been re-appointed Medical Officer of Health to the Warblington Urban District.

The following appointments have been made by the Treasurer:—

House Physicians.—Mr. A. H. Leete (Dr. Hale White); Mr. G. E. Manning (Dr. Pye-Smith).

House Surgeons.—Mr. H. Davies (Mr. Howse); Mr. E. C. Taylor (Mr. Davies-Colley).

Assistant House Physicians.—Messrs. H. A. Munro and E. A. Peters.

Assistant House Surgeons.—Messrs. C. E. Carpmael and F. J. Steward.

Resident Obstetrics.—Messrs. T. M. Thomas (April), L. E. V. Every-Clayton (May), F. S. Brereton (June).

Passim.

The Authorities are indebted to the Committee of the Honourable Artillery Company Football Club, who have arranged a football match with the Guy's XV., on Wednesday, April 3rd, at 4 p.m., to be followed by a grand Smoking Concert, commencing at 7 p.m., in aid of the funds of this Hospital. The Smoker, at which many well-known professional ladies and gentlemen (see notices in Club) have kindly consented to assist, will be held, by kind permission of the Court of Assistants, at the Armoury House, Finsbury, E.C., Lieut.-Col. The Earl of Denbigh, Commanding the H.A.C., in the chair. We hope that all Guy's men will purchase tickets (price two shillings each, to admit to Match and Smoking Concert), which may be obtained of C. E. Michael, H. W. Dudgeon, or H. T. Bell, at Guy's, and thus support the efforts of the H.A.C.F.C. Committee "to realise a handsome sum for this deserving Institution."

The long-expected "Ladies' Night" of the Debating Society, will be held on Friday next, in the Smoking Room, at 8 p.m. We understand that Mr. Anderson will defend the action of the Anti-Gambling League, and that Mr. Higgins will lead the opposition. There will doubtless be a large attendance of members and their lady friends, some of whom, we hope, will give us their views on this burning question.

The Annual General Meeting of the Students' Club will be held on Tuesday next, the 26th inst., at 4 p.m., in the Anatomical Theatre. As the President, Mr. Durham, will occupy the chair, and the election of a thoroughly representative committee is desired, we hope there will be a large number of students present to show that some practical interest is taken by them as to the all-important conduct of their Club.

We are pleased to hear that the Course of Instruction in the Public Health Department of Guy's Hospital Medical School has been officially approved by the Syndicate of the University of Cambridge, and has been placed on their list.

We are sure that all our readers will join us in expressing deep sympathy with Mr. Fripp in the terrible bereavements he has recently sustained.

"Clinical Sketches," for this month, announces a competition for students for the best report of a clinical case, accompanied by original drawings or photographs. The prize is of the value of £3 3s.; and any of our readers who would care to compete, are referred for conditions to the Medical Monthly above noted.

We would call attention to an announcement in the Colonnade that Mr. Laidlaw Purves will give a series of demonstrations on selected cases of Diseases of the Ear, on Fridays, at 2 p.m., during the ensuing Summer Session. The demonstrations will be held in the Aural Outpatient Room, and we feel sure that many men will be glad of this additional opportunity of gaining experience in a somewhat neglected branch of study.

We have received the following communication from the acting secretary of the Lawn Tennis Club, which we willingly give publicity to. "Unfortunately this season we (L.T.C.) are losing the valuable services of both our Captain and Hon. Sec., so if we mean to put a team in the field worthy of the size of our Hospital, we shall have to make a great effort. St. Thomas's and Bart's are, this year, very well represented, and if we wish to be in the running for the cup we must unearth more talent, especially in the junior years. A list for names of those interested has been put in the College Porter's Lodge, but so far, I am sorry to say, it has almost 'drawn blank.' For the benefit of our new members, any information may be obtained from the 'Clubs Union Blue Book' or from Astley V. Clarke."

Once again we have to deplore the defeat which our Rugby representatives sustained at the hands of our old antagonists, St. Thomas's, on Monday last. A full account of the match appears in our columns devoted to "Sport," and though we shared the general disappointment at the reverse sustained by Guy's, we congratulate our more fortunate rivals on their

well-merited victory. The match was an extremely interesting and scientific exposition of the Rugby code, and if we were beaten there was little cause for complaint at the plucky manner in which our men stuck to their work to the end.

The Association Football XI. have, by defeating Middlesex Hospital on Wednesday last, qualified for the final round of the Inter-Hospital Cup. We hope there will be a large crowd to encourage our men when they meet St. Bartholomew's for the possession of the Cup, on Monday next at Leyton.

The Hon. Sec., S. H. Mason, of the Rifle Association, of which Mr. Dunn is President, would be glad to hear from any Guy's men who are riflemen, and are anxious to become members. The first practice will be held on May 2nd, at Ilford.

J. T. M. McDougall and F. E. Walker are this year's winners of the Arthur Durham Prizes for Dissection. We congratulate them on their success, and are pleased to note that one of them, Walker, is also a prominent footballer.

The Physical Society.

The last meeting of this Society for the Session 1894–95 was held in the Club Smoking-room on Saturday evening, March 16th. Dr. Pye-Smith took the chair, in the unavoidable absence of Dr. Wilks, and, by his ready wit and fluent speeches, largely contributed to the success of the meeting.

The Treasurer's Prize Essay was read by the successful competitor, Mr. B. A. Richmond; and an interesting and well-sustained discussion followed.

The Secretary (Dr. Campbell) read a laudatory report of the agenda of the session, and announced Mr. E. Ivens Spriggs as the winner of the first prize of £10 for the best paper read during the session. Mr. Pakes, as a close second, was allowed a special prize of £4 for his paper on Diphtheria.

The resignation of the following old Presidents was accepted:—Messrs. F. G. Hopkins, J. A. Howard, T. D. Lister, H. M. Stewart, A. J. Sharp and G. F. Still.

New Presidents elected:—Messrs. C. H. Fagge, W. S. Handley, W. C. Pakes, L. A. Parry, B. A. Richmond and E. Ivens Spriggs.

Elected to fill vacancies on the Photographic Committee were Messrs. Hallam Hardy and H. T. Hicks.

Votes of thanks to the Treasurer and to Dr. Pye-Smith then followed, and a letter was read from the former expressing regret for absence.

The proceedings then terminated.

The following is the Treasurer's Prize Essay, on "The Pathology of Dropsy," read before the Society by Mr. B. A. Richmond:—

Mr. President and Gentlemen—

The word Dropsy, which is abbreviated from Hydrops (derived from the Greek ὕδωρ = water and ὤψ = a face), is used in this country in a general sense to mean an accumulation of fluid in the connective tissue spaces and serous cavities of the body. This fluid is closely allied if not identical with normal lymph undergoing certain slight changes in composition according to its origin and situation. The dropsical fluid is, therefore, regarded as lymph which under certain morbid conditions is retained in the lymph spaces and serous cavities. The latter may be considered as large lymph spaces which are in communication with the lymphatic system by means of the minute pores or stomata in their serous membranes.

The fluid has received various names according to its situation. The term anasarca (ἀνά and σάρξ = flesh) has been applied to a general dropsy; the term œdema (οἰδέω = to swell) is applied to a local effusion, on the other hand. A collection of fluid in the peritoneal cavity is known as an ascites (ἀσκός = a sac); in the pleura as a hydrothorax; in the tunica vaginalis as hydrocele (κήλη = a tumour); and in the ventricles of the brain as hydrocephalus.

The lymphatic spaces have been compared by Lauder Brunton to large cisterns which have one supply pipe and two exit pipes—the former, capillaries of the part in the walls of the spaces; the latter the veins and lymphatics which drain the tissue. He shows, moreover, that if the exit pipes remain open they will be ample to carry off all the fluid which can enter by the supply pipe. Again, it has been shown by experiment that if one or other of the exit pipes is blocked, the one remaining open can still prevent fluid accumulating in the cistern if the supply of fluid entering is not greater than normal.

Ranvier[1] has tied the inferior vena cava low down in dogs without any œdema of the legs resulting, and a local set of lymphatics may be obstructed by ligature, or excised, without any dropsy following, so long as transudation from the vessels remains normal. Dropsy, then, depends on the quantity of lymph effused being greater than the veins and lymphatics can carry away.

The two factors upon which a dropsy depends are:—

1. Excessive transudation from the vessels.
2. Impeded removal of the fluid by the veins and lymphatics.

The consideration of the first factor leads us to the whole question of lymph formation under normal conditions, and how this may be altered under pathological conditions.

[1] Comptes rendres, lxix., No. 25, 1869.

This question of lymph formation is too large for me to go into it fully, but for the purpose of this essay I have thought it sufficient to give a short review of papers published by Dr. Starling in the *Journal of Physiology*, Vol. XVI., 1894, and in the reports of the Arris and Gale lectures in the *Lancet* for March 31st, April 14th and 21st, 1894.

Ludwig was the first to explain lymph formation by the mechanical laws of diffusion and osmosis. To quote his theory in his own words, he says:—"The blood which is contained in the vessels must always tend to equalize its pressure and its chemical constitution with those of the extra-vascular fluids which are only separated from it by the porous blood-vessel walls. If, for example, the quantity of blood in the vessels is increased, the mean blood-pressure is also increased, and at once a portion of the blood is driven out into the tissues by a mere process of filtration. The same result is brought about when the constitution of the blood is altered by the absorption of food or by increased excretion through the kidneys, lungs or skin, or when the composition of tissue fluids is altered in consequence of increased metabolic changes taking place in the tissues. In the latter case the changes brought about in the lymph are effected by processes of diffusion."

In support of his theory, Ludwig passed defibrinated blood through the vessels of a limb and found that as he increased the pressure so he increased the lymph production. The fact that a constant flow of lymph can only be obtained from the lymphatics of a limb by kneading its tissues at regular intervals supports the mechanistic theory, the effect of the kneading being to empty the lymphatic spaces, diminish the tension within them, and so to produce a greater pressure difference within and without the vessels.

Again, chemical differences between blood and lymph provoke a transference of the substance in excess from one side of the vessel wall to the other. Thus, colouring matters, salts and sugar injected into the blood, appear in the lymph from various parts of the body shortly after. Conversely, Dr. Starling has shown that methylene blue injected into the pleural cavity passes into the circulation and appears not in the lymph from the thoracic duct, but in the urine. Toma, experimenting on the testis with a constant flow of lymph, found that the flow was increased by ligaturing the pampinniform plexus, by which means the venous and capillary pressures were raised.

It was then shown by Paschutin and Emminghaus that no increased flow of lymph was produced by raising the arterial blood-pressure in the limbs of a dog, even when the blood-pressure was raised as high as possible.

Emminghaus also found that an increased flow of lymph from the leg followed either division of the sciatic nerve or ligature of the veins.

These observers were the first to suggest that another factor besides the blood-pressure took part in the lymph formation, and Paschutin regarded this as the living vessel wall.

Rogowicz, working under Heidenhain, introduced a new feature into the research, by the discovery that an injection of curare caused an increased flow of blood from the limb independent of any alteration in blood-pressure. He suggested that curare had a specific action on the cells of the endothelium lining the capillaries.

Tigerstedt further clinched the arguments against Ludwig's theory, by pointing out that there was no comparison between the behaviour of a living and a dead membrane. A frog's lung which under a pressure of 20 ccm. of water will not allow a drop of normal saline solution to pass through it, will, if killed, allow the passage under a pressure of only 1 ccm.

Again, Leber had shown that the great resistance of the cornea to filtration pressure was dependent solely on the vitality of the single layer of cells known as Descemet's membrane.

The lymph obtained from a limb by ligature of the veins was found to contain less proteids than normal and contained also red blood corpuscles, and there appeared no physical explanation of the absence of one and the presence of the other under the same conditions.

Heidenhain introduced new methods into the research by employing the constant flow of lymph from the thoracic duct, which could be obtained with the animal at rest.

The object of his researches was two-fold, to discover the relation of blood-pressure to lymph formation, and the effect of certain substances circulating in the blood on the amount and composition of lymph flowing through the thoracic duct.

1. The first set of experiments consisted in blocking the thoracic aorta and inserting a cannula into the thoracic duct. The lymph was collected at intervals of 10 mins. each, the percentage of solids and blood-pressure recorded in the femoral artery. The result was—

	Time.	Lymph.	Solids.	Blood-Pressure.
(*a*) *Normal*	9·31–9·41	3 cc.	4·75	140 mm.
(*b*) *Aorta blocked*	9·54–10·4	2·6 cc.	4·75	8 mm.
At 9·54	10·4–10·14	3 cc.	5·78	8 mm.
	10·14–10·24	2 cc.	6	8 mm.

Thus the lymph flow altered very little, whereas the pressure fell from 140 mm. to 8 mm. The lymph was whitish and more concentrated after the obstruction, and so regarded as a new formation. Here the factor bringing about a filtration, *i.e.*, the blood-pressure, was absent, and so another factor must be brought in to maintain the flow of lymph. Heidenhain regarded this agent as the capillary wall itself.

2. For a second set of experiments the portal vein was obstructed. The figures were—

	Time.	Amount.	Solids.
(*a*) *Normal*	10·24–10·34	2 cc.	6·5
(*b*) *Portal vein*	10·44–10·54	8·9 cc.	—
Ligatured at 10·34	10·54–11·4	9·5 cc.	—
	11·4–11·14	10 cc.	4

Thus there was a great increase in the flow of lymph, which was more watery. Heidenhain thought that this increased flow might be due to a mechanical filtration.

3. Thirdly, the inferior vena cava was obstructed above the diaphragm with the result that—

(*a*) There was an immensely increased flow of lymph *3 cc.* in 10 mins. to *25 cc.* in 10 mins.

(*b*) Increase of solids in the lymph, the percentage rising in one set of experiments from *4·8 to 6.6.*

(*c*) A great fall in blood-pressure from *125* mm. Hg. to *37* mm. Hg.

It was clearly brought out by these results that—

(*a*) Lymph flow was independent of blood-pressure.

(*b*) Venous congestion was a powerful factor in increasing the flow of lymph and in also altering its characters.

The second part of Heidenhain's research was suggested by the discovery of the action of curare in increasing the lymph flow. On the look out for substances with a similar action, he noticed the effect of crayfish and mussels in producing nettlerash.

From these animals he prepared substances which he called lymphagogues. Peptone and leech extract were found to have similar effects in increasing the flow of lymph. Besides these *colloids*, a second class of lymphagogues was discovered, viz., *crystalloids*, such as grape-sugar and salts of the diuretic class. The effect of injection of the first group of lymphagogues was to increase the quantity of lymph and the percentage of the solids in it. The blood was found after the injection to contain a larger percentage of solids and hæmoglobin, showing that plasma had passed from blood to lymph. The serum, on the other hand, was found to have a smaller percentage of solids, showing that a fluid more concentrated than plasma must have left the blood-vessels. The same effect was produced by peptone, only that a much larger dose was required. Dr. Starling, by means of trichloracetic acid, can demonstrate the presence of peptone in the blood for one to two hours after injection, and within half a minute after injection the peptone appeared in the lymph. The amount of peptone in the lymph increases and in the blood decreases, until in about ten minutes they become equal in amount. The amount in the lymph then further increased until much greater than the amount in the blood, and then both amounts decrease proportionately. As there is no evidence of the destruction of peptone in the blood, it is concluded that it must all pass through to the lymph, *i.e.*, from a solution of lower to one of higher specific gravity. This passage must be due to energy supplied by the secreting endothelium of the capillaries.

The effect of the second class of lymphagogues, the crystalloids, was to increase the amount of lymph and to render it more watery. The blood is also found to be more watery, the plasma containing less solids. The increased flow is, therefore, at the expense of both the blood and the tissues. The passage of sugar—which after injection is found in greater quantity in the lymph than in the blood—from the blood to the lymph must, as with peptone, be accomplished by the secretory activity of the cells.

From these researches, Heidenhain came to the conclusion that the physical processes of filtration and diffusion play only a subordinate part in the formation of lymph, and that lymph is a true secretion dependent for its production on the activity of the endothelial cells of the capillaries.

While, however, under normal circumstances this process of filtration plays no part in the production of lymph, he thinks that under pathological conditions, such as heart disease and cirrhosis, the dropsy, or ascites, may be conditioned by the increased intracapillary pressure acting on a wall already weakened and abnormal in consequence of anæmic and diseased conditions of blood.

From this standpoint, a local œdema from an excessive transudation of lymph would be due to the activity of the cells of the capillary endothelium in response to certain stimuli. These stimuli, arising in morbid conditions, may be of two kinds, one chemical by means of lymphagogues, the other suspected by Heidenhain to be nervous. He thought that the vessel walls might be found to be supplied by secretory nerves, in which case the so-called nervous œdema might be practically demonstrable in the laboratory.

Turning now to Dr. Starling's recent paper, we shall see whether these conclusions and expectations have been borne out by more recent research.

With regard to the effect of blood-pressure on the lymph flow, Heidenhain assumed that the capillary pressure was proportional to the arterial blood-pressure, whereas Bayliss and Starling[2] have pointed out that there is a variable element in the peripheral resistance formed by the arterioles interposed between the arteries and the capillaries. An increase of pressure in the arteries may cause a dilatation of the arterioles without any rise of capillary pressure. The venous pressure gives a better indication of the capillary pressure, because there is no unknown or varying resistance between. They show how difficult it is to ascertain the state of the capillary pressure under varying conditions; but it is certain that if both the arterial and venous pressures fall the pressure in the capillaries must be diminished, and if the pressure on both sides of the capillaries rises then the intracapillary pressure will rise.

This condition they show to exist in the condition called by Cohnheim "Hydræmic Plethora," in which the whole volume of the blood is increased and the blood diluted by the injection of a quantity of saline solution into the circulation.

In his experiment on the effect of the obstruction of the inferior vena cava on the lymph flow, Heidenhain went a step further to ascertain the source of the lymph. He tied the vena cava some distance below the hepatic veins and found no further increase in the flow of lymph. He now opened the abdomen and squeezed the intestines; this led to an increased flow, whereas squeezing

[2] "Journal of Physiology," vol. xvi., 1894, p. 159.

the liver had no effect. From this he concluded that no lymph came from the liver, and all the increase came from the intestines. If this were so the lymph so obtained ought to be identical with that obtained on obstructing the portal vein, whereas, turning to the experiment, we find that from vena cava obstruction we have a concentrated lymph, from portal vein obstruction a watery lymph. Dr. Starling further noted on repeating the experiment that the intestines were blanched after the obstruction of the vena cava. This he thought might be due to a stimulation of the splanchnic nerves by the effect of a low arterial pressure on the vaso-motor centre; that the splanchnics, in fact, might contain lymph-secretory nerves. Division of the splanchnics, however, had no effect in modifying the results of the experiments. The blood-pressure was reduced still further, but the obstructed vena cava had just the same effect on the lymph flow; and so with the portal vein obstruction. Dr. Starling then thought that tissue-fibrinogen might be formed in the stagnant blood in the liver and act as a lymphagogue. Complete defibrination of the blood did not disturb the results, however.

It was then noticed that the lymphatics in the hilus of the liver were distended after death from obstruction of the inferior vena cava. By the ligature of the majority of the lymphatics of the liver, which leave at the portal fissure along with the hepatic vein, it was found that the effects of obstructing the vena cava might be reduced to a minimum. And so he proved that the whole of the lymph obtained by this obstruction was derived from the liver, and not from the intestines, as Heidenhain had suggested. The reason why pressure on the liver fails to drive out a drop of this lymph, while squeezing the intestine caused a great flow, depended on the fact that the lymphatics from the liver run in the upper part of the mesentery attached to the duodenum. When a single coil of intestine was squeezed carefully, and no traction was made on these trunks, no increase in the flow resulted. The lymphatics of the liver are protected from pressure by the solid framework of connective tissue in which they are embedded. The increased flow of lymph from the liver was shown to be dependent on the intra-capillary pressure, for when the pressure on the liver capillaries and vena cava was relieved by obstructing the aorta, the flow of lymph was at once diminished. The varying composition of the lymph was attributed to differences in the permeability of the capillary walls.

The capillaries of the limbs have only a small permeability; the lymph obtained from them contains 2 to 4 per cent. solids.

The intestinal capillaries are more permeable, so that the normal blood-pressure is sufficient to increase the transudation and cause increased flow from the duct. The percentage of solids in this lymph is 4·5 to 6 per cent.

The liver capillaries are most permeable, and are extremely sensitive to changes in pressure. Their lymph contains 6 to 8 per cent. solid material.

Another factor altering the composition of the lymph is the varying concentration of blood plasma in different parts of the circulation. It had been shown by Hamburger that the amount of proteids in the plasma or serum was increased at the expense of the blood corpuscles on the addition of acids to the blood, alkalies having the reverse effect. The additional carbonic acid in venous blood may act in this way, and so enable the plasma in the veins and capillaries to hold more proteid in solution. The chief blood-supply of the liver is venous, so that the plasma in the hepatic capillaries will contain more proteid and yield a more concentrated lymph.

The typical lymph of venous congestion, however, is more watery than normal, and this difference seems rather to depend upon the permeability of the capillary walls than upon the intracapillary pressure, for when this pressure is very great a diapedesis of red blood corpuscles takes place, not a rise in the percentage of the solids in the lymph.

Dr. Starling found that the obstruction to the vena cava brought about certain changes in the blood. Thus, the percentage of solids in the whole blood had increased, an increase due to the relative decrease in the amount of blood plasma. Further, the percentage of solids in the serum fell from 7·33 to 7·02, while those in the lymph rose from 6·46 to 7·102, changes similar to those produced by lymphagogues.

Heidenhain's conclusion from this was that in order to make the lymph more concentrated, a fluid more concentrated than plasma must have passed through the capillary walls, a process only to be explained by secretion.

But to this conclusion there are two objections—one, that if a fluid more concentrated than plasma were secreted in the lymph, then the lymph from the thoracic duct should be more concentrated than blood plasma, which is never the case after the injection of lymphagogues; the other, that the changes in the composition of the plasma are quite independent of the nature of the exudation leaving the vessels.

The diminution in the total solids in the serum may be explained as due to the fact that while concentrated lymph is being poured out in the liver, the fall in the systemic pressure due to the obstruction of the vena cava will lead to a resorption of lymph from the tissues.

With regard to the action of lymphagogues, the effect of the crystalloid group may be explained on mechanical grounds.

After the injection of large quantities of sugar, water is attracted from the tissues, and the blood is increased in quantity and diluted. The condition of "hydræmic plethora" is produced. Bayliss and Starling have shown in this condition there is a general rise of capillary pressure, especially in the abdominal organs, the veins of which become engorged with the additional fluid. Dr. Starling thinks that the same factors—pressure and permeability—will also explain the effects of the colloid lymphagogues. The lymph produced by these he regards as being derived from the liver, just as in obstruction to the inferior vena cava.

Many lymphagogues are found to cause a fall of arterial pressure with a rise of pressure in the inferior vena cava and portal vein, so that the pressure in the hepatic capillaries must be increased.

These bodies also affect the coagulability of the blood, and it is thought that they may so alter the capillary walls as to increase their permeability.

The search for lymph-secretory nerves has so far proved futile, and Dr. Starling could not confirm the statement of Ostroumoff, that stimulation of the lingual nerve invariably produced œdema of the tongue.

As a result of various experiments in which he divided the cord, stimulated the splanchnics or the vagus, he came to the conclusion "that there is no evidence of a direct influence by the nervous system on lymph production."

The fuller investigation of Heidenhain's own experiments resulted, therefore, in establishing Ludwig's views on a firmer basis. The formation of lymph was found to depend mainly on the two factors:—

(1) Increased intra-capillary pressure; and

(2) A greater permeability of the walls.

Turning now to pathological conditions, let us see how these physiological processes are modified, and how far they will help us in explaining the production of a dropsy, either local or general.

The conditions under which the intra-capillary pressure is raised are:—

1. Obstruction to veins.
2. Arterial dilatation.
3. Altered conditions of blood.
4. Undue laxity of the tissues.

1. As examples of dropsies due to venous congestion we have ascites from obstruction of the portal vein, and the dropsy of heart disease, the mechanical character of which is shown by its strict conformity to gravity.

Along with the latter we may include the œdema of emphysema and the effusions into the peritoneum, pleura and pericardium, which occur in the later stages of chronic granular kidney, as distinct from the sudden œdema which appears as one of the first symptoms of Acute Bright.

As long ago as 1670, Richard Lower, in his "Tractatus de Corde," showed that ligature of the inferior vena cava above the diaphragm produced an ascites, but when the ligature was applied lower down an œdema of legs only occasionally resulted. Ranvier showed that the latter result was more constant if the sciatics were previously divided.

Phlegmasia dolens, again, may be quoted as an œdema in which the thrombosis of the iliac and femoral veins plays an important part.

2. Arterial dilatation has been regarded as the cause of the œdema of the lower extremities, which is a common symptom in fractured spine, with compression of the cord. Strubing considered that the œdema was due to a stimulation of the vaso-dilators.

Jankowski produced œdema in the hind limb of a dog by scalding the paws. Salvioli found that after rendering dogs hydræmic, œdema resulted only in the limb in which the sciatic had been divided. In Ostroumoff's experiment on the tongue the vessels of the tongue dilated after irritation of the lingual nerve, and any œdema resulting must have been due to this arterial dilatation.

3. Altered conditions of the blood have a considerable influence on the capillary pressure. Thus, a watery condition of the blood, as in "hydræmic plethora," has been shown to increase the capillary pressure, although Cohnheim and Lichtheim,[3] rendering dogs artificially hydræmic by injecting large quantities of saline solutions into the circulation, have shown that this condition of itself will not produce a dropsy, although it produces an increase in the flow of lymph from the thoracic duct.

Hamilton[4] has suggested that any alteration in the specific gravity of the blood may aid in the production of a dropsy by increasing the difficulty in circulating the blood corpuscles, and so raising the intra-capillary pressure.

4. Lastly, an undue laxity of the tissue will increase the capillary pressure in proportion to the extra vascular tension, which in this condition is reduced to a minimum. For this reason the œdema of acute Bright appears first in soft areolar tissue, such as that of the eyelids and scrotum. This loss of elasticity probably acts in another way in the production of dropsy, by allowing the lymph to accumulate and distend them instead of assisting in its removal.

The conditions affecting the permeability of the capillary wall may be divided into:—

1. Inflammatory processes.
2. Morbid conditions of the blood.
3. Long-continued venous congestion.

1. The effect of inflammation on the vessel walls is shown by the following experiment. By plunging a dog's leg into water at 60° C. for five minutes, an inflammatory œdema was set up. The ordinary blood-pressure was now sufficient to cause a transudation of lymph too great to be carried off by the lymphatics and veins. Further, Jankowski found the flow of lymph from an inflamed limb is more affected by nerve influence and venous congestion.

These results can only be explained by supposing the permeability of the limb capillaries to have been increased. An increased transudation of fluid into the tissues is a feature of all inflammations, but this liquid differs markedly from the fluid of simple œdema and dropsy. Roughly speaking, it contains a larger quantity of albumin, and also contains the elements for the formation of fibrin, and so is coagulable, a property most dropsical fluids do not possess.

The following table[5] will show the difference more exactly:—

[3] Virchow, Archiv., lxix., p. 103.

[4] "Text-book of Pathology," vol. I., p. 324.

[5] Halliburton, "Chemical Pathology," p. 346.

Case.	Specific Gravity.	Proteids per cent.	Fibrin.	Serum Globulin	Serum Album.
Acute Pleurisy	1023	5·132	0·016	3·002	2·114
Hydrothorax (chronic Bright)	1015	2·5	0·0067	0·402	0·9154
Do. heart disease	1016	1·48	0·013	0·779	0·75
Hydrocele fluid	1019	5·005	0·059	1·352	3·594
Subcutaneous œdema (cardiac dropsy)	1013	0·592		0·139	0·453
Do. (Bright's disease)	1009	0·6404		0·1911	0·4493

Compared with this, *blister fluid* contains leucocytes, and has a specific gravity of 1018 or more, together with a large percentage of proteids.

Hydrocele fluid, in many respects, resembles an inflammatory effusion, but does not clot spontaneously unless mixed with blood or serum, or containing a large quantity of leucocytes. It appears, therefore, to be on the border line between a true inflammatory exudation and a dropsical transudation.

2. Other factors, however, appear to produce dropsy by increasing the permeability of the vessel walls. The most important of these are abnormal conditions of the blood.

The cachectic dropsy which occurs in anæmia, chlorosis, malaria, scurvy, etc., and the dropsy which is common in famines from long-continued slow starvation, are explained by this means. The nutrition of the capillary walls is insufficiently maintained, and thus their permeability is increased, and they allow an increased transudation. Certain substances circulating in the blood appear to have a similar effect on the vessel walls.

Gaskell first showed that dilute acids cause relaxation of the muscular substance both of the heart and blood vessels, while dilute alkalies have an opposite effect. Brunton and Cash,[6] experimenting on a frog by injecting acids into the circulation, found that the vessels dilated and the tissues became œdematous from an increased transudation into them. Alkalies similarly injected had the effect of constricting the vessels.

Heidenhain[7] stimulated the chorda tympani in an animal which had been poisoned with atropine, with the result that the submaxillary gland became congested without there being any increased secretion from its gland cells, or any increase in the quantity of lymph in the cervical lymphatics.

The absence of salivary secretion can be explained by the specific action of atropine upon the secretory nerves, but the absence of œdema can hardly be so explained. Atropine must have some action on the vessel walls, and this, Lauder Brunton considered, was similar to that of alkalies. Experiments have been described in which, after injection of dilute hydrochloric acid into the duct of the gland, subsequent stimulation of the chorda tympani produced œdema of the gland.

[6] Lauder Brunton, "Disorders of Digestion."
[7] Pflüger's Archives, V., p. 309.

In warm climates a general anasarca comes on suddenly during the rains and affects natives and Europeans alike. Dr. Brunton seeks to explain this œdema as due to some failure in the functional activity of the sweat glands. He thinks that some substance having a similar action on the vessel wall to that of acids may be retained in the cutaneous capillaries. Urticaria[8] "is an acute inflammatory œdema of the skin." "The effusion takes place very rapidly, and may be called forth either by a mechanical or by a chemical irritant, as in the wheals produced by the nettle." Lauder Brunton thinks that the cause of this œdema will be found to be due to a paralysis of the secreting powers of the sweat glands, and that changes may take place in the secreting cells by which acid substances are produced. These, when retained, act on the vessel walls. It is significant that Heidenhaim discovered his lymphagogues by noting the effect of certain foods, such as crayfish and mussels, in producing nettlerash. So that the action of these bodies may be partly explained on the same grounds.

The amount of proteid in the transudation fluids of heart disease is usually greater than in other forms of pressure dropsy, and this led Wooldridge to the conclusion that the dropsy of heart disease was partly due to an altered condition of the blood.

3. Lastly, a long-continued venous congestion acts on the vessel wall, stretching it, and so increasing its permeability. Examples of this are shown by the effusions into the serous cavities which take place in the later stages of chronic Bright, and by the late œdema of emphysema and chronic bronchitis.

Lauder Brunton mentions a case in which the permeability of the capillary walls was not affected until some time after the onset of the disease, and then the œdema appeared quite suddenly and gave immediate relief. Salvioli pointed out that in his experiments on dogs the skin never became œdematous. This was thought to be due to the fact that œdema of the skin in human renal disease was due to a gradual stretching of the tissues, and that in dogs the tissues are more resistant to venous distension.

We have still to consider the opposite aspect of the subject—the question of the exit pipes or the impeded removal of lymph from the lymph spaces.

This may be caused by obstruction to either outlet, or to both. The obstruction to a local set of lymphatics is not found to produce dropsy, owing to the fact that the removal of lymph can then be carried out by the veins. Obstruction to the veins leads to an œdema when their function cannot be replaced by the increased action of the lymphatics, or the blood returned by anastomotic paths. But obstruction to the venous channels also produces œdema, as we have seen, by raising the capillary pressure, and so producing an increased transudation. Where both veins and lymphatics are obstructed, as in applying a bandage tightly round a limb, a copious local dropsy sets in.

[8] Fagge and Pye-Smith, vol. II., p. 830.

Any factor disturbing the natural circulation of the lymph will indirectly cause the retention of this fluid in the spaces. So that in the question of impeded removal we have to consider such factors. The circulation of lymph depends upon the circumstance that the pressure within the large venous trunks into which the main lymphatic vessels open is less than that existing in the tissues. The flow of lymph is further assisted by certain accessory forces which include (1) the contraction of muscles; (2) the movements of respiration; (3) contraction of the muscular coat of the lymph vessels.

A constant flow of lymph can only be obtained from the limbs by kneading the muscles or bringing them into action.

The action of respiratory movements in removing lymph from the peritoneum is shown by Ludwig's experiment upon the central tendon of the diaphragm of a rabbit. The parts below the diaphragm were cut away, the thorax inverted and artificial respiration kept up. A quantity of pigment in suspension poured over the diaphragm was drawn into its lymphatics which thus became deeply injected. The action of the lymphatics themselves in propelling the lymph is best seen in the frog, where contractile sacs or lymph hearts are met with.

Any condition, then, in which the respiratory movements are deficient or the pressure in the large venous channels is raised by backward pressure, or the muscles are flabby and inactive, would tend by the hindrance to the lymphatic circulation to the production of dropsy.

Lauder Brunton accounts for the fact, that short-haired dogs yield more lymph than long-haired dogs on these grounds: the muscles of the former are harder because the muscular faciæ are more rigid and so have a greater effect in squeezing the lymph out of the lymphatics.

To classify the forms of dropsy according to their causation we may distinguish three principal forms—

1. The dropsy of passive congestion, or that due to disordered conditions of the circulation.
2. Hydræmic dropsy, or that due to disordered conditions of the blood.
3. Inflammatory œdema, or dropsy due to disordered conditions of the blood-vessels.

In all these forms there are probably several factors at work, and it is impossible to draw a hard and fast line between them.

Clinically, we have the cardiac, hepatic, renal, scarlatinal, and anæmic forms of dropsy.

Cardiac dropsy is mainly due to passive congestion.

The factors being an increased capillary pressure due to the venous congestion, an increased permeability of the capillary walls due to malnutrition and long continued stretching, and finally, a deficient removal of lymph from the lymph spaces, owing to the obstruction to the outlet of the veins.

Wooldridge[9] regarded the symptoms of heart disease-dropsy, intra-vascular clotting, and hæmorrhagic infarction as due to an antoinfection or fibrinogen poisoning. He found that if the femoral vein of a normal dog was ligatured, no œdema resulted, but "if a solution of fibrinogen be injected into the circulation through the jugular vein, and the femoral is then ligatured, either the most extensive and rapidly developing simple œdema occurs, or an enormous hæmorrhage," *per diapesin* "takes place throughout the tissues of the limb, or the two are combined." To obtain this effect, he found that the substance must be injected rapidly, or that the current of blood at the seat of injection should be slow. Lymph does not normally poison the blood, because it runs in slowly while the blood circulates rapidly; in heart disease, however, the blood circulates slowly, and the conditions necessary for the infection exist.

[9] Proc. Roy. Soc., xlv., p. 311.

Renal dropsy is of two forms, the general œdema, which appears early, and the later effusions, due to failing circulation.

The anasarca of Bright's disease was naturally regarded as dependent upon the changes in the urine; that it was due both to the retention of water in the system and the loss of albumin from the blood. With regard to the former, Cohnheim and Lichtheim proved that the watery condition of the blood known as Hydræmic Plethora did not of itself produce dropsy, although predisposing to that condition. That a complete suppression of urine is quite compatible with the absence of any œdema is shown by the anuria of hysterical women, and the "obstructive suppression" resulting from plugging of the ureter of a single kidney, the other kidney having been destroyed by disease.

As for the loss of albumin, Cohnheim pointed out how small this was compared with the amount lost by suppuration and in chyluria without any dropsy resulting.

On the other hand, Hamilton points out the tendency to inflammation and hæmorrhages which exist in albuminuria, and thinks that these may be explained by changes in the specific gravity of the plasma, due to the loss of albumin. The œdema appears so early, that Cohnheim considered that the vessels of the skin and subcutaneous tissues might be affected by the same cause which set up the nephritis. From this it would seem that he regards an alteration to take place in the vessel-walls, similar to that which results in inflammation, and from his standpoint the œdema would be inflammatory. Against this, we have the striking difference in chemical composition between the fluid of the subcutaneous œdema of Bright's disease and that from an inflammatory condition, such as blister fluid.

In *hepatic dropsy*, we have the best example of a dropsy due to venous congestion. The portal congestion producing an increase in the intra-capillary pressure in the intestinal capillaries; and in the later stages, also affecting the permeability of their walls by the long-continued distension.

Scarlatinal œdema has been regarded as inflammatory, mainly because it sets in very early, before there is any evidence of an impairment of the renal functions.

Amongst local œdemas may be mentioned the lymph scrotum and lymphatic œdema of the leg in elephantiasis.

The cause of this condition most usually accepted is that it is due to the blocking of the lymphatics and glands by the parasite known as Filaria Sanguinis Hominis. The œdema of the face and limbs due to the invasion of the Trichina Spiralis, has been assigned to several causes. The latest researches point to it being of an inflammatory nature, due to the irritation caused by the parasites.

Chronic hydrocephalus may be given as another example of a local dropsy, but its pathology is by no means clear. It has been ascribed, with an equal lack of evidence, to an obstruction to the veins of Galen, and to the great yielding capacity of the cranial vault.

It appears, then, probable that we may explain the production of most dropsies by mechanical laws. In all forms the condition depends ultimately on the physical condition of the capillary walls. Whether the vitality of the endothelial cells plays any part in the normal transudation of fluid is not yet settled, but whatever this part may be it seems probable that under pathological conditions it is reduced to a minimum, and that physical forces and agencies play a greater part in consequence.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Specialism in Medicine, and Medical Teaching.

Dear Sir,—It is rather late to comment upon Medical Specialism, but the subject is important, and you may find space for a few remarks. Specialism in Medicine may be considered from more than one point of view. There may be specialism in research, in practice, or in teaching. Specialism may possibly have its value under certain conditions, but not in others.

In research, a medical scientist, unless he happens to be an exceptional genius, will probably do more work of lasting value if he elucidates one point after another in connection with the diseases of one of the systems of the body, than if he tries to do a little here, a little there, and then something somewhere else. We have, for example, to be thankful that some workers in nervous diseases have been narrow-minded enough to have been specialists, at least, so far as research is concerned.

The specialist in research may, however, become the specialist in practice. Under these circumstances, there is always a danger of his judgment becoming biassed, and of his arranging all human ailments around the organ on which he is particularly interested.

In spite of this danger, there must, nevertheless, be many instances in which the opinion of a man who has made certain diseases his special study, will be of more value than that of a man who has given those same diseases little thought.

We have been speaking of specialism in its narrower aspects, but Mr. MacIlwaine, at least so far as teaching is concerned, wishes to break down the time-honoured barrier between medicine and surgery. He thinks that the school that would furnish teachers capable of dealing with all subjects at the same time would start a new epoch in medical education.

Mr. MacIlwaine thinks that even now this system might be started, and that the members of a hospital out-patient staff have sufficient knowledge to adopt it.

Mr. MacIlwaine, however, speaks as if he thought that medical education begins and ends in diagnosis and treatment. The more difficult points of etiology and prognosis are forgotten. Yet how much of a student's reputation in after life depends upon the accuracy of his statements concerning the causes and the dangers of disease.

While one considers that etiology and prognosis require a deeper knowledge than diagnosis, one would not be prepared to admit that the refinements of that art could be taught indiscriminately by any member of the staff in any group of diseases.

The best all-round teacher (from the examination point of view) would possibly be a student who has just passed several examinations with honours. It is not, however, prominent text-book facts that one learns from a physician or surgeon of experience, but points that escape the attention of the majority which he has learnt to be of value. From one member of the staff who has his own particular likings we gain this information, and from another, with other tastes, we obtain knowledge of different character. It is not the laboured commonplace teaching that produces a definite impression and wins the lasting confidence of students, so much as the spontaneous importation of facts that by expression and manner the teacher shows that he made his own.

The student, in order to become a "good all-round man," does not need to find in every teacher a trainer of the surgery diagnostician. His future skill depends upon his power to appreciate the value of knowledge presented to him, and his capacity to assimilate it. A man that needs to be "crammed" will never be an ornament to his profession, although it must be admitted that for the safety of the public, "cramming" in his case may be necessary.

Teaching, however, ought not to have for its only aim the imparting of useful knowledge. Students need to be taught how to observe and to think. Those who, at the end of their hospital course, know how to observe and to think, will remain learners. Their hospital education will be the shaft leading to a mine of knowledge, not the mine itself.

In closing, I may say that nothing seems to me to be so dwarfing to the intellect as want of variety. Annihilate personal tastes, and provide a teaching staff of one common level of uniform and universal interest and the student's career would become one dull round of monotony, and his mind a medley of inflexible dogmas. Such a school, instead of rising to the heights to which Mr. MacIlwaine imagines, could be nothing but lustreless. The fame of a school rests not only

upon its educational advantages, but upon the reputation of its teachers. The men that Mr. MacIlwaine would select are not those who would add to the knowledge of medicine and bring honour to themselves and to their pupils.—I am, dear Sir, yours truly,

Clifton, Bristol. THEODORE FISHER.

Weana Schnitz'l;

OR,

STUDIES IN LITTLES.

No. II.

Nextly, let it not be thought that any or all of the Littles that strike your correspondent's wonder are universal customs amongst the Weana. In the ordinary examination of a chest, the use of a dead rather than of a living pleximeter is to be noticed. Then, in auscultation, here we see only the direct application of the doctor's ear; there we see the wooden stethoscope; where do we see the binaural ditto? Not to lay down the law too strictly, perhaps the last is the rarest, the second the rarer, the first the common. When doubtful or faint are the sounds, various combinations and permutations of the three are the rule. If certainty cometh not with the one method—Try Another. But "Dass Kölbchen, bitt'ich!" is the cry. Merely to test and localize the vocal fremitus—a simple chemical flask (about 250 c.c. capacity) whose mouth is applied to the patient's chest, whose globe is held in the physician's hand. Hast tried it? If not, why not? But hardly; if so, why? But this is interposed, for no exposition has been offered of how the camel is gulped down and the knat spat forth. For often it is to be seen that much care in self-protection is taken in the examination of diphtheritic throats. To this end we see panes of glass, mounted much as ladies' hand-mirrors, held up by the one hand, as the other directs the tongue spatula. In a more complete form we see a large lens inserted in the middle of the pane; in a yet more perfect form an ordinary but silvered incandescent lamp, with travelling wires, is mounted before the glass. That there may be no distortion of the image, the glass is fashioned from a hollow sphere. So much for the expectorated gnat! The sequent auscultation of the sometimes slime-besmeared chest without instrumental interposition (sc. stethoscope) should surely be enough of the bolted camel—e'en though it be but a young one! . . . . It really makes one feel quite at home to see that the "Durhamsche tracheale Cannüle" is used, and liked here. But though your correspondent has seen the like in some English hospitals, he forgets how many sets of the same are to be found in Guy's. But is there any connection betwixt them twain? . . . .

In surgical wards, when such cleansing is required, the irrigator has ousted the brazen germy syringe. The reservoir hangs high o'er a wheeled table; the nozzle, with its handy tap, wets its whistle, almost externally, in a jar of tinted sublimate. "Another syringeful! sister, please," is as little heard as the thin still voice of the conductor's baton. . . . . But how is't with soap? What are these orange triquetrous bottles? And what do they contain? Is't better, is't cleanlier, is't safer to pour fresh limpid soap from out a flask 'pon surgeon's hands and patients' skins, or t' use a cake thereof—which, though peerless may often hide its head in dinginess. What think you o't? Think you aught 's in it? Nay, in truth, 'tis but aqua, sapo mollis viridis, spiritus vini, et acidum salicylicum—this last, 'tis said, for fun. . . . . .

Several Weana have remarked to your correspondent "that Wien is one hundred years behind London." They make a routine of antisepsis in all gynæcological examinations. . . . . .

Acidum Salicylicum? Why thus? What next? A little Little? Yes, only take care of the copper Kreuzer, and the greasy Guldens will be pleased to please themselves. Hast followed it? No? Then to the "Leitmotiv"—given that two drugs have practically the like therapeutic action, in hospital practice use the cheaper. Acidum salicylicum and sodium salicylicum are of the same price, ostensibly—but a Littler of the former goes the longer way: therefore is it used. Nay, there are some that do affirm that its action is the better. Now to the exception—sure proof of the rule—a new drug is to be tried—it is—that's all. In the London Hospitals, with their overflowing coffers, who would think of such Littlenesses? Who would prescribe an alum rather than a zinc sulphate astringent wash? In Oe. W. the first costs but two-thirds of the latter. Jam satis.

Wien. Δ.

Erasmus Wilson Lectures on Pathology.

Syllabus of lectures to be delivered at the Royal College of Surgeons, by J. H. Targett, Esq., M.S., on "Neuropathic Joint Disease."

Lecture I., April 1st, 5 p.m.—Introductory and historical notes—syringo-myelia, summary of clinical symptoms and pathology. Morbid changes in bones and joints. Illustrative cases, with description of specimens. Characters of the articular lesions reviewed.

Lecture II., April 3rd, 5 p.m.—Syringo-myelia, its varieties; other lesions associated with it; spinal curvature. Morvan's disease—its morbid anatomy and relation to syringo-myelia. Causation. Joint-disease in locomotor ataxy—its different types. The pathological appearances met with in the knee and elbow-joints.

Lecture III., April 5th, 5 p.m.—Changes in the shoulder-joint, hip, and pelvis in locomotor ataxy. The tabetic foot—its clinical symptoms and morbid anatomy. Other joint lesions resembling ataxic arthropathy. Conclusion.

Each lecture will be illustrated with lantern plates.

A Theory of Eczema.

An instructive case of so-called Idiopathic Eczema came under my notice lately. A blacksmith complained of great irritation about his forearms, and showed me a lot of little congested spots. I diagnosed, *pro tem.*, obstructed sweat-ducts. Next day he remained in bed and sent for me; there was an erythematous blush about the flexures of the elbows, with tiny vesicles; temperature was slightly raised; no albuminuria. In a day or two the flexor surfaces of almost all the large joints were covered with typical eczema.

May we, without theorizing too much, look at the sequence of events thus: A sudden checking of the sweat, especially on the bare forearms, in coming out of a hot forge, the retained excretion leading to pyrexia and an irritating condition of sweat, this to hyperæmia of sweat-glands over a considerable area of the body with temporary blocking and then increased action of the glands, and, of course, an accompanying dermatitis?

I have lately been watching daily a case of subacute eczema in which the stages were these:—first, numerous small points of congestion appeared on the skin, with very great irritation; then followed a merging of the spots into a general deep redness with considerable swelling of the skin, and a pretty copious weeping from the surface; this was followed by a subsidence of swelling, etc., and a branny desquamation. The trunk, except on the front of the chest, went through the same stages, beginning a few days later than the arms. On the arms the eruption stopped at the deltoids above, and the wrists below. Head, neck and lower limbs remained normal, while elsewhere the rash looked like an ordinary eczema, rags being stiffened by the discharge in the usual way. The spots about the loins and flanks did not coalesce, and here the discharge, though it looked like the so-called serum of eczema, clearly came from the sweat-ducts, and during the drying-up stage the mouth of each affected duct could be seen with a lens to be filled by a hard, transparent-looking, amber-coloured, lenticular body, scores of which could be collected on the point of a knife; they were then seen to be mixed with branny scurf, apparently adherent to the under surfaces of the scales.

What is the so-called serum which escapes from the weeping surface of eczema, and how does it get there? Surely the serum of the blood does not wander promiscuously through the cuticle when there is a line of so much less resistance via sweat-duct and gland. Is this fluid not over-abundant sweat mixed, like the urine of acute Bright, with a quantity of albumin owing to the congested surroundings of ducts and glands?

In every case of eczema, whether idiopathic or from known cause, have we not a skin capable of assuming a certain condition under irritation and sweat, known to be capable of producing that very form of irritation?

Beginning with eczema intertrigo, here we apply the sweat to the skin and partially obstruct its discharge and produce the eczema; in baker's itch we block the ducts, accumulate the sweat, and the dermatitis follows; in scabies the parasites interfere with the ducts with the same result; the heat of sun or mustard produces congestion of the skin with, at least, partial obstruction of the flow of sweat, and if applied with enough severity a genuine dermatitis results. Probably in some cases of idiopathic eczema the process is reversed, so to speak, the sweat becoming primarily abnormal and irritating.

I should therefore suggest, as a definition of eczema: A dermatitis due to irritation by sweat, either primarily abnormal and irritating, or rendered so by being unduly in glands and ducts, or in contact with the surface of the skin.

South Petherton. S. W. MacILWAINE.

Cases of Acute Dysentery.

Perhaps a brief report of two cases of Acute Dysentery treated with Pulv. Jalapæ Co. and Calomel, might be interesting to the readers of the Gazette.

Case I.—Woman, æt. 40, a first-class passenger from Durban, Natal, to Cape Town, had been passing mucus and blood per rectum for three days. I found her much prostrated, face pale and pinched; temperature 102·2; had been passing frequent dysenteric stools, which, upon examination, consisted entirely of mucus of a greyish brown colour, mixed with blood. There was tenderness over the large intestine, and much tenesmus. I gave at once Pulv. Ipecac. gr.xv.; it was rejected ten minutes later with much retching, which increased prostration. When she quieted down, gave gr.x. of Ipecac. and gr.i. of Pulv. Opio., this was also rejected; opium enema relieved somewhat the tenesmus, which was a very prominent symptom.

Dr. Considine, of Port Elizabeth, kindly saw the patient in consultation, and advised me to give her Pulv. Jalapæ. Co. gr.xlv., and Hydrarg. Subchlor. gr.iv., and as he has had much experience in dysentery, I followed his advice, although it seemed to me heroic treatment.

The next morning patient passed several fæculent motions, with less amount of blood and mucus, and was in other respects manifestly better. The improvement continued, and when landed at Cape Town, two days later, was convalescent, though very weak. She was sent to Somerset Hospital and made an uninterrupted recovery.

Case II.—Dr. L., a first-class passenger, January 3rd, felt out of sorts; January 5th, had diarrhœa and headache; next morning, January 6th, found him flushed, pulse quick, 110, soft, compressible, no pain upon pressure over abdomen; passed eight motions during night, scanty (did not notice their appearance); temperature 101·2 F. On examination of next motion, found no fæcal matter, but mucus in masses, of dark brown colour, intermixed with pure blood; it had a bad odour.

He now complains of slight pain over sigmoid flexure and tenesmus upon going to stool; temperature in evening, 102·2 F. Gave him Pulv. Jalapæ. Co. ʒss. Calomel gr.iv. Milk diet.

7th. Much better, headache less, pulse 90, temperature 99·2 F. Passed a better night, used bed-pan three times, passing fæculent matter. In the motion previous to the action of the purgative, there was about an ʒi. of blood. Improvement continued during day; passed one soft, fæculent stool during afternoon; evening temperature 99 F.

8th. Still improving, headache gone, pulse 84, temperature 98·4 F. Passed natural motion during night, with very little mucus, no blood; temperature, evening, normal.

9th. Improvement maintained, slight trace of mucus, which disappeared next day and, with the exception of weakness, was feeling well.

I shall continue to try this treatment in any other case of acute dysentery I may have, as in Dr. L.'s case it quickly cut short a severe attack. The improvement after fæculent matter was passed was very marked. Dr. Considine goes so far as to say that in early stages of acute dysentery you can *always* cure by above treatment.

R.M.S. "Roslin Castle," Cape Town. H. KNIGHT RAYSON.

The Oxford Medical School.

The last few months have seen changes in the Oxford Medical School which have given rise to much anxiety to all its old members, and have now been terminated with satisfaction, at least, to the majority of them. In December of last year, the Regius Professor of Medicine, Sir Henry Acland, resigned his post, which he had held for fifty years, and Professor Burdon-Sanderson was elected to succeed him. Last week, the Waynflete Professorship of Physiology, thus vacated, was filled by the election of Professor Gotch, Holt Professor of Physiology in University College, Liverpool. Sir Henry Acland may be said to have founded the Oxford Medical School some twenty years back in the building by the University at his instigation of the great museum, in which Mr. Ruskin displayed much practical interest, and to which are attached nearly all the laboratories of Natural Science belonging to the University. Professor Burdon-Sanderson, on his appointment in 1883, at once set to work to procure a laboratory of physiology worthy of Oxford, and to make temporary arrangements for the study of the other subjects of the "1st M.B." examination, which corresponds to the "Intermediate" of the London University. Mr. Gotch worked with him as demonstrator for eight years, and during that time conducted many of his most valuable pieces of research with Professor Victor Horsley and others.

In 1892, the new Laboratory of Human Anatomy was opened. This is perhaps the finest institution of its kind in this country; the dissecting-room, lecture-theatre, museum, demonstrators' and curators' rooms, photographic room, and basement for injection and other purposes, with lift to the ground floor, being all perfect, and fitted with every valuable innovation. Arrangements are made, too, for constant streams of water to flow over the roof in summer, keeping the room beneath at as low a temperature as is pleasant to work in.

Hardly less praise can be bestowed on the Physiological Laboratory; and most complete arrangements have now been made for the course of Organic Chemistry in the University Chemical Laboratory, and for that of Materia Medica in a large room used until recently for purposes of Human Anatomy. Similar improvements have been made in the courses for the Preliminary Scientific Examinations; and the staff throughout could hardly be equalled elsewhere.

The question is constantly asked as to how the Oxford school can compare with that of the sister University. As regards numbers, it is, of course, largely inferior, there being at Oxford but twenty to thirty men working in the dissecting-room, the whole school numbering perhaps 60; but this is anything but a disadvantage to the men themselves, and many hope that it will never reach the proportions of the school at Cambridge. Indeed, there are good reasons why, under the present regulations, it cannot do so; for it is compulsory at Oxford to take a final school for the Arts degree in some one subject, and that usually chosen is, of course, physiology. The curriculum for this school extends far beyond what is essential for the future understanding of medical and surgical questions, and occupies so much time that no man can pass his preliminary, B.A., and 1st M.B. examinations in less than four years. Few will say that the further insight which this course gives into methods of scientific thought and investigation is in any way wasted upon the future practitioner; but there are not many to whom the opportunity is given of availing themselves of the great advantages afforded by this young medical school.

In conclusion, it may be said that the outlook under the auspices of Professors Burdon-Sanderson and Gotch is most inspiring. The new Regius Professor is intent on founding a course of systematic study of those parts of Pathology which can be studied academically; although it never will be deemed advisable to supplant in any degree the clinical teaching of the London hospitals. It may be noticed that Professor Sanderson served last year on the Royal Commission on the subject of the Gresham University, and that London medical students may at no distant future feel the effects of his views on the subject of medical education which he then so clearly and forcibly expounded. F.

Practical Chemistry.

Students are required to pay the fee for this Class, held during the Summer Session, on May 1st. The fee is £2 7s., and not £2 10s., as announced in our last issue.

Appointments.

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. A. P. Beddard, C. H. Bryant, W. G. Mumford, H. W. Collier, J. H. Horton, H. A. Moffat.

Dressers in Eye Wards.—Messrs. H. J. Milbank-Smith, P. E. Tresidder (Mr. Higgens); J. B. Leathes, C. L. Hopkins (Mr. Brailey).

Surgeons' Dressers.—Messrs. A. S. J. Pearse, E. R. Thomas, T. Davies, F. A. Godson, R. Hedden, G. B. Muriel (Mr. Howse); A. G. Butler, J. B. Parfitt, M. C. Hayward, F. W. Ta'Bois, C. W. Booker, G. E. Duncan, (Mr. Davies-Colley); H. T. S. Bell, N. H. Pike, W. A. Horton, P. C. Prince, E. N. Scott, T. B. Poole (Mr. Lucas); W. I. Hancock, H. S. Desprez, A. J. Dolman, P. G. Temple, R. T. Brown, F. H. Hardy (Mr. Golding-bird).

Assistant Surgeons' Dressers.—Messrs. E. Fisk, G. K. Levick, W. E. Plummer, S. Whicher, H. V. Smith, W. C. Milward (Mr. Jacobson); W. R. Wood, A. H. Bell, E. D. Hancock, W. J. S. Harvey, C. E. Michael, W. T. Clarke (Mr. Symonds); C. A. C. Askew, F. J. Lidderdale, D. L. Smith, J. H. Jones, T. J. Vick, J. M. Fortescue-Brickdale (Mr. Lane); W. E. Hills, D. B. Todd, R. S. Rowland, M. H. Way, C. C. Worts, C. R. Nicholson (Mr. Dunn).

Post-mortem Clerks.—Messrs. W. J. Rowland, P. N. Vellacott (April and May); A. H. Spicer (May and June).

Obstetric Ward Clerks.—Messrs. B. F. Pendred, H. J. Spon.

Obstetric Out-patient Clerks.—Messrs. J. Hora, W. L. Garner, H. R. T. Fort (1st half); F. J. H. Cann, R. F. Clark, P. R. Lowe (2nd half).

Aural Surgeon's Dressers.—Messrs. E. Coleman, R. H. Ashwin, R. E. Delbruck, E. E. Henderson.

Dental Surgeon's Dressers.—Messrs. R. H. Hayes, W. H. Peake, A. Salter.

Clerks in Skin Department.—Messrs. W. L. B. Davies, F. W. Rowland.

Assistant Surgeons' Clerks.—Messrs. C. C. A. Salmon, A. H. Finch (Mr. Jacobson); H. C. Regnart (Mr. Dunn).

Medical Ward Clerks.—Messrs. W. C. Pritchard, D. Rice, H. Leader, V. E. Collins, A. W. Ormond, W. F. Reckitt, C. T. Anderson, R. P. Rowlands, E. Ivens Spriggs, C. P. Weekes, A. B. Carter, R. Howard, J. Moore, E. Moore, A. Earnshaw, A. J. Wernet, S. C. Clapham, H. Fulton, E. C. Hort, F. W. Lee, C. H. Mossop, A. M. Rygate, H. Bernard-Onraët, E. F. Clowes, J. Dixon, Edward Evans, A. T. Falwasser, C. J. Francis, F. C. Hitchins, C. Jephcott, H. R. Marsh, E. H. Pomeroy, J. Ponsonby, J. T. Roberts, R. B. Stamford, P. C. Higgins.

Assistant Physicians' Clerks.—Messrs. J. Howell, G. Burton-Brown, R. Kay, H. Simson (Dr. Pitt); H. T. Hicks, N. Lavers, J. N. Gardiner (Dr. Shaw); N. Instone, C. R. Evans, F. Golding-Bird, N. Y. Lower (Dr. Washbourn).

Surgical Ward Clerks.—Messrs. E. S. Hall, C. R. Hodgson, S. H. Longhurst, W. N. East, A. Kinsey Morgan, W. H. M. Smith, H. J. Starling.

Externs.—Messrs. B. P. O. Neill, H. T, S. Bell, A. G. Butler, J. B. Parfitt, N. H. Pike, M. C. Hayward, H. E. Izard.

Clerks to Anæsthetists.—Messrs. C. F. Wakefield, W. L. Stuart, W. L. B. Davies, M. E. Tresidder, C. D. Edwards, C. H. Fagge.

Dressers in the Throat Department.—Messrs. H. A. Hinds, C. J. Harnett, M. P. Jones, R. O. Moon, L. G. Reynolds, B. A. Richmond, A. A. H. Partridge, G. L. Eastes.

Dental Appointments.

The following Dental Appointments have been recommended by the Dental Committee, and approved by the Treasurer:—

Assistant Dental House-Surgeon.—Mr. E. C. Dimock.

Demonstrators in the Conservation Room.—Messrs. J. W. Lewis (till June 30th); E. D. Bascombe, H. C. Cowles, L. Ta'Bois (till September 30th).

Curator of the Dental Laboratory.—Mr. K. W. Goadby.

Dressers in the Gas Room (April).—Messrs. J. L. Payne, B. G. Tasker, E. G. W. Wallis.

Dressers in the Ordinary Extraction Room (April).—Messrs. Guy Chatterton, C. N. Doyle, L. S. Hounsell, H. Knight, A. E. Oddy, A. St. J. Styer.

From the Gazette's Special Pathologist.

All specimens — particularly those of solid tissues— should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

W. F. C., Fulham.—We were unable to find any tubercle bacilli in the pus and *débris*.

G. F. H., Balham.—1. A few tubercle bacilli in the sputum. 2. No tubercle bacilli could be found in the sputum.

W. L. W. M., Huddersfield.—No tubercle bacilli could be found in the sputum.

R. G. R., Lowestoft.—The culture yields an almost pure growth of the bacillus diphtheriæ.

C. R. A. S., Sidcup.—No tubercle bacilli could be found in this sputum.

S. A. W., Manchester.—The tumour is of a nævoid character, aud is situated immediately beneath the mucous membrane. There is no evidence of any malignant growth in the specimen.

M. W. O., Bideford.—The growth is a scirrhus carcinoma widely infiltrating the surrounding tissues.

A. H. W., St. Leonards.—Tubercle bacilli are present in fairly large numbers.

PATHOLOGIST.

Professor Stuart Blackie.

The following good story told of the late Professor Stuart Blackie, which has already obtained considerable publicity, may not inappropriately find a place in our columns:—

There are certain days in the student year at Edinburgh University when a holiday is declared. On one such occasion the Professor, arriving early at the classroom, entered before the class had assembled and wrote in chalk on the blackboard the words:—

THE CLASSES WILL NOT MEET TO-MORROW.

He then retired to his private room. The men assembled and wiled away the few minutes prior to the Professor's entry by the usual songs. But one wag, struck with a happy thought, skipped up to the platform and rubbed out the "C" of the word "classes," leaving the scroll to read thus:—

THE LASSES WILL NOT MEET TO-MORROW.

Roars of laughter greeted this stroke of student humour, and in a few seconds the whole class settled down to await the arrival of the Professor. The door on the platform opened, and the Professor appeared. This was the signal for an outburst of hilarity that literally shook the windows in their frames. The Professor stared in astonishment at the class, standing there in front of the blackboard, with his back towards it, a spectacle of blank amazement. The laughter grew deeper and louder as his hand wandered nervously towards his necktie and over his silver hair, as if to enquire whether his personal appearance could explain this demonstration. But no, his dress and all were quite as usual. On a sudden he wheeled round, and his eye caught the alteration in the notice on the blackboard. Almost as quick as thought the agile Professor seized the duster, and striking out another letter, left the notice to read as follows:—

THE ASSES WILL NOT MEET TO-MORROW.

Of course the laughter was now greater than ever. The Professor had turned the tables on the practical jokers; and with a self-satisfied twinkle in his eye he called the "boys" to turn their attention to their work.

Sport.

Rugby Football.

SEMI-FINAL TIE.

GUY'S v. ST. THOMAS'S (Holders).

This match was played on Monday last, at Richmond, before an enthusiastic crowd numbering about 1,000, and, as everybody knows by this time, resulted again in a win for the holders by 13 points to 0. The score hardly indicates the relative merits of the two fifteens, as Guy's were not badly beaten. The game was the best we remember to have seen in any Hospital Cup Ties from every point of view. The weather was everything that could be desired, and the ground being in perfect condition the play was open in character and never became uninteresting from start to finish. Forward there was little to choose between the rivals, and it was perhaps this which was mainly responsible for the openness of the game. Of the forwards, Nicholson, Dudgeon, Goddard, Tyson, and Rowland, played a good game for us. The difference in the teams became at once noticeable whenever the ball left the scrummage; Guy's were unquestionably bettered at half. On the Thomas's side, Montague and Rotherham, more especially the latter, played *the* game for their side; the passing was swift and clean, and Rotherham never missed an opportunity to make an opening for his three-quarters. On the other hand, Jackson and Guy were not altogether at ease; their passing was not up to form—occasionally it was ill-judged and even bad—and although individually they made brilliant attempts to stem the tide of ill-luck which beset the team, Guy's were unable to break the line of their opponents' defence once throughout the entire game. The opening which Jackson made for Guy's in the early part of the game was the result of a clever move, and it was hard, very hard, to see the chance of scoring lost. Of the three-quarters, Thorman stands out head and shoulders above them all; his wonderful dropped goals were among the features of the match; and it is seldom indeed that a player achieves so much for his side as did their captain for St. Thomas's on Monday last. Greg also played a sound game for them; the other two, Browne and Patch, were never dangerous. Of our own three-quarters, Rae played well throughout, his tackling being especially good; he was a little too slow in getting in his kicks at times. Bertie Hancock was not in his best form. In the early part of the game he was obviously "off," but as the play warmed he was seen to better advantage, especially in the second half, where some fine attempts at dropping at goal deserved a better fate. In the last quarter of an hour, Hancock showed some of his sterling qualities by perhaps the finest run of the day. Receiving the ball by some good passing between our half-backs, and initiated at about half-way, with a beautiful swerve he skilfully avoided the Thomas's backs, and was within an ace of scoring when,

hardest of hard luck, he was brought down from behind. Bell had not many opportunities, but he seems to have lost some of his pace, and his tackling was hardly so good as usual. Wetherell was the weakest of our line. Alexander's tackling was as safe as ever, and he brought Thorman down beautifully twice in succession during the first half. The performance of our team was by no means discouraging, they showed unlimited pluck, and there was a considerable amount of dash individually—and occasionally collectively among the forwards—who proved themselves to be very clever with their feet. We lacked combination, or at any rate our combination was not quite so good as that of St. Thomas's, and hence we suppose the now alas! almost stereotyped phrase, "*On the day* the best team won." As already noted, the game was one to get very excited over, and play was distinctly up to first-rate form. No football match is ever destitute of humour, and especially when there are lady spectators. We overheard the following about five minutes from time: Very young lady (wearing Guy's favour, and who had been intensely enthusiastic throughout) "Oh! Mr. Jones, *is* Guy's winning?" Jones (whose despondency is too deep almost for words, and who has been answering this sort of thing about every two minutes) "I * * * am * * * afraid * * * not." V.Y.L.: "I *am* sorry, but they don't seem to mind—I'm sure they play quite friendly!"

THE GAME.

Guy's were unlucky in losing the toss, and at 3.25 the following were the teams which faced each other. Guy's defending the goal near the entrance. Teams:—

GUY'S.—K. B. Alexander (back); H. T. Bell (captain), W. I. Hancock, F. C. Wetherell and F. L. Rae (three-quarter-backs); T. L. Jackson and A. Guy (half-backs); R. S. Rowland, R. J. Rowland, H. W. Dudgeon, E. G. Goddard, P. A. Dykes, W. Tyson, P. D. Hunter and C. R. Nicholson (forwards).

ST. THOMAS'S.—C. F. B. Moggridge (back); E. W. Browne, W. H. Thorman (captain), A. H. Greg and B. G. Patch (three-quarter-backs); A. Montague and A. Rotherham (half-backs); A. E. Elliott, A. Rouillard, H. R. Sedgwick, G. O. Bingham, G. H. Dominy, L. Gilbert, A. Arkle and G. Beley (forwards). As will be seen, Thomas's were without the services of Adair-Thompson and F. M. Bingham.

Dudgeon kicked off for Guy's, and play immediately settled down in the Thomas's twenty-five. The Guy's forwards attacked vigorously, and the ball was taken dangerously near their opponents' goal line. Passing amongst our backs was unproductive, and the Thomas's three-quarters were tackling and defending well. From a scrummage inside the Thomas's half, in which our forwards had the best of matters, Jackson received the ball from Guy and dashed away, with Rae on his right and Hancock and Bell outside. He had matters entirely in his favour, and by passing to Rae, who was unmarked, a try for Guy's seemed almost certain. However, he transferred to Bell by a beautifully-judged long pass, which was as well taken by the latter at full pace, but he was too well marked, and the effort was unfruitful. Guy's continued to press for more than five minutes. Our forwards were heeling well, but our backs were not at their best, and a bad pass from Jackson along the ground to Hancock let St. Thomas's men through, and play was transferred to the middle, where Alexander kicked into touch. Thomas's now assumed the aggressive, and some beautiful passing was carried on by their back division, but our line of defence was too strong at this time. Rotherham was here playing a great game, and made repeated openings for Greg and Thorman, who were effectually stopped by Hancock and Bell. In one of these sallies Browne got possession, but was grandly collared by Alexander on the line, where a scrummage was formed. The Thomas's forwards getting the ball, heeled, and quick passing between Rotherham, Montague and Thorman, culminated in the latter dropping a magnificent goal, twenty-five minutes from the start, amidst tremendous cheering. On the re-start, Thomas's again pressed, and Alexander relieved by a long kick into touch. Immediately after this, a fine piece of passing among the Thomas's backs was badly spoilt by Patch, who failed to take his pass, and Rae relieved by a splendid dribble along the touch line. Moggridge improved matters for Thomas's by a kick into touch and from the line-out the Thomas's forwards broke away, Alexander saving grandly. From a stubborn scrummage in our twenty-five, Rotherham again gave his three-quarters a chance, and after a brilliant run Thorman scored a try well out, which Rotherham converted. Soon after half-time sounded, Thomas's leading by 9 points (2 goals, 1 dropped) to 0.

In the second half the Guy's forwards more than held their own, and the Thomas's defence was strongly tried, but luck was all against us, several fine attempts at dropping at goal by Hancock narrowly escaping success. Led by Elliott, the Thomas's forwards got away, and relief was further given by good kicks by Moggridge and Thorman. Thomas's were penalised for off side, and Hancock made a fine attempt to kick a goal, which fell short. More fine open play on the part of our rivals, and Thorman added a second dropped goal for his side—the state of the game being, Thomas's 13 points, Guy's 0. Guy's now played up very hard, and passing amongst our backs considerably improved. Our forwards, who throughout stuck to their work in a most determined manner, put in some very pretty foot-work in the open, Nicholson, Rowland, and Dudgeon especially showing up, and became dangerous, when Moggridge relieved by throwing forward. From a scrummage inside the Thomas's half, a very fine effort on the part of our backs, and especially of Hancock, almost enabled us to score. And so the game ended, Guy's doing all they knew to score, the Thomas's defence, however, being too sure. Mr. Gardner (Kensington) was referee.

GUY'S 2ND XV. v. OLD MERCHANT TAYLORS "A."

This match was played at the Old Deer Park, Richmond, on Saturday, March 16th, and resulted in a win for Guy's by 2 tries to a goal from a mark. Owing to

one of our forwards having failed to read his name in the list of the team, and another not having got out of bed, we were two short, but our six forwards more than held their eight opponents. Cleveland kicked off, and we at once began to press, Morgan scoring from a pass by Bagshawe, which was unconverted. The O. M. T.'s then worked the ball into our twenty-five, and one of their men kicked a goal from a mark. The game from now to the finish was of a scrambling nature, Guy's several times getting over the line, mainly through the agency of Thorpe, but the referee remained obdurate. On the call of time, Pike broke away cleverly, and, passing to Saward, the latter scored; Guy's winning as above. Clarke at back kicked and tackled well, while our backs at times passed very well. Team:—

Guy's.—W. T. Clarke (back); T. Morgan, A. C. Ransford, N. H. Pike and G. B. Muriel (three-quarters); H. T. Hicks and R. S. Thorpe (halves); A. J. Cleveland, H. V. Bagshawe, A. H. Saward, G. R. Rowe, G. Shoreland and N. Williams (forwards).

Association Football.

INTER-HOSPITAL CUP TIE.—SECOND ROUND.

GUY'S v. UNIVERSITY COLLEGE HOSPITAL.

This match was played at Richmond in beautiful weather, on Tuesday, March 12th, and resulted in a win for Guy's by 4 to 0. Among the spectators we were pleased to notice Dr. and Mrs. Shaw, and Dr. Bryant. Our front rank was slightly disorganised because one of the eleven scratched at the last moment, preferring to attend a dance rather than assist his Hospital in a Cup Tie. Such unsportsman-like behaviour is unknown in the annals of Guy's football, and we hope this will be the first and last example of it. Fortunately, our captain found an able substitute in Waymark, who, considering he had not played before for us this season, combined extremely well with the other forwards.

Guy's, having lost the toss, kicked off against wind and sun. We immediately attacked, and showed some very pretty combination, which resulted in Fitz-Hugh scoring a magnificent goal eight minutes from the start. Keeping up the pressure, we simply bombarded the University citadel, and at the end of twenty minutes the score stood, Guy's 4, University 0, the extra points having been put on by Stamford (1), Waymark (2). Following this, our forwards slowed down considerably, and University immediately took up the running, but our defence was far too strong to be penetrated by their spasmodic efforts. At half-time the score remained unaltered.

In the second half the play ruled more even, and though Guy's had slightly the best of it, they failed to avail themselves of many good opportunities, through the old faults—slackness in front of goal and weak shooting. University tried hard to score, and made some dangerous rushes, which, however, came to nothing, although Barwell made one or two very good attempts. On time being called, we thus qualified for the Semi-Final by 4 to 0.

Turning to individual players, Walker was undoubtedly the best man on the field, his play at centre half was much admired, but he is still inclined to kick a little too hard. Davis at back was a great acquisition to our team, and played a very good and safe game, although handicapped by a weak ankle. Humphrey was the pick of the forwards, and the way he diddled the opposing backs was much admired; he is, indeed, the gamest member of the eleven. Team:—

Guy's.—N. Lavers (goal); W. R. Davis, A. R. Smith (backs); R. H. J. Swan, F. Walker, A. E. Crosby (half-backs); P. S. Mandy, W. E. Waymark, R. T. Fitz-Hugh, R. B. Stamford, L. Humphrey (forwards).

Inter-Hospital Cup Ties.

ASSOCIATION FOOTBALL.

Results to date, March 20th, 1895.

1st Round—

A. University beat St. Mary's, 5—2.

Guy's, St. Bartholomew's, King's, St. Thomas's, London, Middlesex, and Charing Cross drew byes.

2nd Round—

B. St. Bartholomew's beat London, 8—1.

C. Middlesex v. Charing Cross (latter scratched).

D. St. Thomas's beat King's, 6—1.

E. Guy's beat University, 4—0.

Semi-Final Round—

F. St. Bartholomew's beat St. Thomas's, 12—0.

G. Guy's beat Middlesex, 4—2.

Final Round—

Guy's (Holders) v. St. Bartholomew's. To be played at Leyton on Monday, March 25th.

Birth.

HETLEY.—On March 5th, at Beaufort House, Church Road, Norwood, the wife of Dr. Henry Hetley, of a daughter.

Marriage.

PETERS—SERJEANT.—On March 7th, at Ramsey, Edwin Arthur, B.A., M.B. Cantab., younger son of Edwin Peters, of West Dene, St. Leonards-on-Sea, to Alice Mary, eldest daughter of F. R. Serjeant, of Westward Ho! Ramsey.

Death.

HIGGINBOTTOM.—On February 24th, at 56, Shakespeare Street, Nottingham, Marshall Hall Higginbottom, surgeon, aged 72.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette,

APRIL 6, 1895.

Spinal Curvature in Nervous Disorders.

By J. H. TARGETT, M.S., F.R.C.S.

The occurrence of certain forms of spinal curvature in association with several classes of nervous disorders is barely mentioned in surgical text-books, yet assuredly the subject should find a place in our experience if not in our books. Let us take one or two examples.

In *locomotor ataxy*, curvature of the spine must be very rare indeed. There are not more than half-a-dozen well-reported cases to be found. Quite recently I had the opportunity of examining such a case. The patient was an infirm woman of 46, practically bed-ridden from advanced locomotor ataxy, the symptoms of which were well-marked. She had no joint or bone lesion other than that of the spine. Situated in the dorso-lumbar region and involving chiefly the first lumbar, was an angular curvature producing a not very obvious boss. On either side of the affected spine there was much bony thickening. Laying one's hand upon the boss and directing the patient to bend forwards (she was in the sitting posture), the vertebræ shifted on each other with a loud "crunch," readily heard by all standing near. It seemed as if the spine were broken at a certain level, and that the lower end of the upper fragment, so to speak, played in a cavity formed by the upper end of the lower fragment—a kind of mortise and tenon joint. When the patient attempted to turn her chest while sitting up in bed there was the same crunching noise, but the movement caused no pain. Though the visible curvature of the spine was not very great, it must have been so in reality, for the thorax approached the pelvis in front closely, especially on the right side where the lower ribs, I think, actually did touch the iliac crest.

What is the nature of this deformity? There can be no doubt at all that the woman has ataxic joint disease of the vertebral column. Probably the disc between two bodies has disappeared, together with much adjacent osseous tissue; hence the angular curvature with some lateral bending as well. Osteophytes formed around the body and processes of the eroded vertebræ would explain the thickening felt.

In one or two of the cases on record the destruction has taken place at the lower end of the lumbar spine. Here the lower end of the upper fragment has been displaced forwards, so as to form an extreme degree of spondylolisthesis, and produce a hard well-defined abdominal tumour. Under chloroform it was possible to move the pelvis on the spine at the seat of disease.

An autopsy made on another case revealed the following conditions:—There was a sharp angular curvature of the spine at the level of the first two lumbar vertebræ, with its apex directed backwards and to the left. The first lumbar body was worn away into the shape of a wedge, with its base to the right, thus giving the spine a lateral deviation. The second lumbar appeared much enlarged, because its body and transverse processes were covered with an abundant osseous formation. Many of the adjacent lumbar and thoracic vertebræ showed osteophytes. There was no evidence

of inflammatory changes, caseation, or new growth.

Syringo-myelia.—Curvature of the spine has been met with in this disease in nearly half the number of cases. Some writers give a higher percentage even than this. It is generally a scoliotic curvature with a small amount of kyphosis, but pure kyphosis or lordosis seems to be very rare. As a rule the curvature comes on some time after the onset of the disease with its curious nerve phenomena, though cases are recorded in which it preceded the dissociation of sensibility by some years. Probably in such cases the scoliosis was of the usual type in adolescents, and in no way referable to the syringo-myelia. It must be admitted, however, that there are good arguments on both sides of this question. One important difference in the two affections is that the curvature occurring in syringo-myelia is not often attended with pains in the back, and that the friends are more likely to notice something wrong than the patient himself. This was so in a case recorded by Dr. Galloway. I had the opportunity of examining the patient a few weeks ago, and her clinical history is briefly this:—She is a stout woman, aged 49, and her illness began some 24 years ago with a sunstroke which rendered her unconscious for two hours. After this attack she noticed a gradual loss of feeling in the right hand and arm, followed in due course by muscular weakness and atrophy of these parts. Three or four years ago her right elbow-joint became diseased, and is now in an advanced state of destruction. Latterly her friends have told her that she was becoming round-shouldered. On examining the back, a distinct spinal curvature was found in the upper dorsal region, with its convexity to the right or affected side. It was chiefly scoliotic, that is to say, lateral with rotation; but there was also some kyphosis which made the deformity into a rounded hump. I should have said that her senses of pain and temperature were lost, but not that of touch. A proof of this was evident in the many scars of burns upon her forearm, received during her work as a washerwoman. Once she pinned her shawl on to her right breast, and was not aware of the occurrence for a long time afterwards. The altered sensibility was limited to the right upper extremity, and the right half of the chest, neck and head.

Another case is under the care of Dr. Mott. He is a man about 24 years of age, who has had symptoms of syringo-myelia for some seven years. His illness began with club-foot, for which he was treated by various operations in St. Bartholomew's. After that he had perforating ulcer, for which he came into Guy's, and the leg was amputated. Since then he has developed disease of the opposite foot, and there is now marked muscular atrophy in the upper extremities. Indeed, it was by testing the wasted muscles that the syringo-myelia was discovered, for though they reacted to galvanism no effect was produced by the strongest Faradic current. His sensibility was then examined, and the characteristic changes were revealed. At the present time the poor fellow shows extreme wasting of the interossei and thenar eminences on both sides, as well as of the extensors in the forearm. In other parts of the body, too, there is marked wasting. None of the joints are diseased, excepting those of the right tarsus, and there the lesion amounts to a general thickening of the part, with incurvation of the front of the foot and a mixture of cavus and varus. I examined it carefully, but could not make sure of the outline of all the tarsal bones owing to the inflammatory thickening and œdema. There has been a large chronic ulcer across the sole of the foot, but this is now healing. As regards his back, there is scoliosis of the upper dorsal region, as in the preceding case, with convexity to right. In both these cases the superficial muscles of the back, especially the trapezius, feel soft and flabby.

A third case was under Dr. Ormerod a few years ago. A lad, æt. 19, first noticed a feeling of pins and needles in his right hand some seven or eight years ago. Since that time both hands have gradually wasted, and the fingers are now in the position of interosseal paralysis. There is also some wasting of the forearms, especially the *right*. The spinal column shows a well-marked lateral curvature in the mid-dorsal region with its convexity to the *left*. Sensations of touch and pain are both practically normal, but there is loss of thermal sense over the right upper extremity and the right side of the neck, as well as in the left arm below the elbow. Muscular reactions to galvanism are normal; to Faradism, diminished or absent; no R.D. present. From the chronic muscular atrophy, the loss of thermal sense, and the scoliosis, the case was diagnosed as one of syringo-myelia.

The seat of the curve is usually in the upper dorsal region, and if severe will be associated with a compensatory curve below. Its convexity looks to the side on which the disease is most pronounced, whether that was first

affected or not. Conflicting statements on this point show that further investigations are required, particularly as to the state of atrophy of the spinal muscles on the two sides. In the first case above mentioned the symptoms of syringo-myelia are entirely in the right upper extremity, and the convexity of the spinal curve is to the right. Dr. Starr records a case in which the muscular atrophy gradually invaded the hand, arm, shoulder, and wall of chest on the right side only; there was loss of temperature sense but no atrophy on the left side. The spinal curve was in the dorsal region with convexity to the right, and it seemed to be entirely due to weakness of the spinal muscles. In opposition to this is a case reported by Hallion, of a man aged 32, whose illness began six or seven years previously with weakness of the right arm. He gradually got worse, and both upper extremities became affected, though the right side remained the worse. At the age of 28 the scoliosis began, and in course of time an extreme degree of deformity was produced. The main curve, however, was to the left (not right) side and involved the whole of the thoracic as well as the adjacent ends of the cervical and lumbar regions.

The causation of this spinal curvature in syringo-myelia has been much discussed, and the various opinions may be arranged under three heads:—

(*a*) That it is due to atrophy of the muscles of the spinal column, especially the transverse series, such as the trapezius, rhomboids, serrati, etc. For various reasons this is quite insufficient.

(*b*) That it results from a destructive arthritis of the joints connected with the spine of the same nature as the articular lesion in locomotor ataxy.

(*c*) That the scoliosis is a trophic lesion which is favoured by muscular atrophy and perhaps by unopposed muscular contraction, as in the scoliosis of Friedreich's disease.

Of these (*b*) and (*c*) are much the same, since they both imply a nutritive disturbance of the joints, bones, and ligaments connected with the spine, such as is known to occur in the joints of the upper extremities. All that is wanted is post-mortem evidence of this vertebral arthropathy in syringo-myelia, which is not at present forthcoming. When that is granted there is still room for mechanical influences to bring about the rotation, which is an important difference between the curvature of syringo-myelia and locomotor ataxy.

Morvan's Disease.—Dr. Morvan found scoliosis present in six cases of this disease out of twelve examined by him. The curvature involved the whole of the thoracic region and was generally convex to the right, as in ordinary scoliosis, but it was not very marked, so that the patients did not know of its existence. There seemed no relation between the scoliosis and the presence of joint lesions in the limbs. On the other hand, the convexity of the curve was towards the side first affected with Morvan's disease, *i.e.*, the right side, in males particularly. As regards the pathology of the deformity, Morvan thinks that the scoliosis should be placed alongside of the whitlows, the joint disease, the spontaneous fractures, and the bony outgrowths as instances of trophic lesions. This affection is allied to syringo-myelia in so many ways that one would expect the spinal curvature to be of the same nature in each.

In *Friedreich's disease*, the spinal curvature appears three or four years after the onset of the malady, and resembles ordinary scoliosis, or it is complicated with considerable kyphosis, or with lordosis in the lumbar region. The cause of the deformity has been attributed to contracture of muscles, analagous to what occurs in the paralytic club-foot of this disease. But it is more probably the result of mechanical forces and the want of resistance of the spinal muscles, as in the ordinary scoliosis of puberty. The position of the foot is that of equinus or equino-varus with marked hollowing of the sole. At the same time the first phalanges become over-extended, while the distal are flexed. This is particularly well seen in the great toe where the first phalanx assumes a position at right angles to its metatarsal, and the extensor proprius hallucis tendon stands out prominently beneath the skin. Such a deformity in no way differs from what may be seen in infantile paralysis, though it is wholly unlike the tabetic foot. It cannot be due to muscular spasm for the joints remain flaccid. Hence it is concluded that the weakness of certain groups of muscles (those in front of the leg, the interossei, etc.) is associated with physiological shortening of their antagonists; the same explanation is applicable to the curvature of the spine.

Our space is exhausted: not so the catalogue of nervous disorders in which spinal curvature is an important symptom. Enough has been said, however, in illustration of the subject. In the routine clinical examination of a spinal curvature, the possibility of its being a "nerve case" should not be forgotten.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	11.	Irregular heart.
	19.	Ulcerative endocarditis.
	23, 36, 42.	Mitral stenosis and regurgitation.
	25.	Mitral regurgitation.
	40.	Aortic stenosis and regurgitation. Mitral regurgitation.
Philip	12.	Aortic regurgitation. Phthisis.
	20.	Mitral regurgitation. ?Aortic regurgitation.
	32.	Mitral regurgitation.
	39.	Aortic and mitral regurgitation.
Stephen	16.	Ulcerative endocarditis.

Nervous System.

Mary	24.	Exophthalmic goître.
	47.	Chorea.
	36.	Syphilitic myelitis.
Stephen	5.	Ataxic paraplegia.
	6.	Senile chorea. ?
	12.	Cerebellar tumour. Optic atrophy.
	13.	Exophthalmic goître.
	30.	Locomotor ataxy. Abductor paralysis of cords.
	34.	Cerebral tumour. Optic atrophy.
	38.	Myelitis.

Alimentary System and Abdomen.

Mary	1.	Gastric ulcer.
	8.	Hydatid (?) of liver.
	29, 38, 39.	Typhoid fever.
Philip	7.	Gastric Ulcer.
	8.	Jaundice. Enlarged liver.
	11.	Membranous colitis.
	16.	Tuberculous peritonitis.
	22.	Appendicitis.
Stephen	1, 4.	Appendicitis.

Genito-Urinary System.

Mary	4.	Diabetes mellitus.
	57.	Acute nephritis.
Philip	6.	Chronic tubal nephritis.
	10, 10, 14.	Diabetes mellitus.
	18.	Acute nephritis.
	25.	Chronic nephritis.
Stephen	19, 25.	Diabetes mellitus.
	23.	Chronic interstitial nephritis. Cardiac hypertrophy and dilatation.

Respiratory System.

Mary	22.	Pleuritic effusion.
	32.	Broncho-pneumonia. Chronic phthisis.
	34.	Pleurisy.
	35.	Pneumothorax.
Philip	3.	Broncho-pneumonia.
	13.	Pleuritic effusion.
	17.	Bronchitis.
	26.	Fibroid lung. Bronchiectasis.
	28.	Pleuritic effusion.
Stephen	2.	Chronic phthisis. Enlarged liver and spleen.
	7.	Pleuritic effusion.
	31.	Syphilitic laryngitis.
	33.	Pneumothorax.

Phthisis.

Mary	16, 18, 50.	
Philip	5, 12, 19, 21, 38.	
Stephen	35.	

Miscellaneous.

Mary	25.	Papular syphilide.
	26.	Herpes zoster.
	30.	Psoriasis.
	37.	Osteo-arthritis.
	41.	Erythema nodosum.
	44.	Acute rheumatism.
	48.	Hodgkin's disease.
Philip	4, 34.	Gonorrhœal rheumatism.
	27.	Acute rheumatism.
	32.	Plumbism.

Some Cases from Clinical.

Tommy R., æt. 12. Admitted January 18th, on fourteenth day of his illness, for pyrexia, great weakness and diarrhœa. He first began to feel ill fourteen days ago, when he complained of occipital headache. Three days later he felt too tired to go to school, so was allowed to stay in bed. He got worse, having pains all over him, but especially in his abdomen. He vomited frequently, and the act was accompanied by bleeding from his nose. At this time also he had a bad cough, and diarrhœa, with very loose yellow stools—the bowels acting about a dozen times a day. This condition remained unchanged till two days ago, when there was some delirium at night.

On Admission.—Pulse 128, temperature 104·6, respiration 38. Drowsy condition, some quiet delirium. Abdomen full, spleen easily felt, no spots seen. Some bronchitis. Sordes on gums and two dirty-white strips of fur on dorsum of tongue. Urine is of febrile type and contains albumin. Existence of diarrhœa soon verified; stools loose, watery and yellow.

Progress.—Delirium passed off, and patient became very noisy and difficult to manage. His manner when examined was aggressive, and he shouted continually, so that morphia injections became a necessity. The high fever was kept moderately under control by

repeated spongings, which only made patient more rebellious. The fever gradually declined throughout the fifth week, and reached the normal on the thirty-fourth day of the illness. At this time a pleuritic rub developed on the right side at the base of the lung. A rise of temperature accompanied this, and the occurrence of a subcutaneous abscess over the sacrum. When this was opened the temperature fell to normal, only to rise again with the formation of an empyema, which had been missed by the exploring needle, and which burst into the lung. On the forty-first day of the illness, while straining at stool, he suddenly was seized with an attack of urgent dyspnœa; he became cyanosed all over, and death from asphyxia appeared imminent. Examination revealed a tympanitic note over right base, with amphoric breathing and bruit d'airain. The crisis was tided over by injections of strychnine and brandy, and by continuous oxygen inhalations. Patient being anæsthetised by his asphyxial condition, a thorough search was made with the needle for pus, and as soon as it was discovered the empyema was cut down upon, and 12 ounces of exceedingly foul pus evacuated. Patient rapidly improved, and although the temperature continued oscillatory, and the boy was for a few days delirious, he may be said to have steadily improved from this time. The empyema closed up in a little over a month, and the boy steadily gained in strength and weight. He is now convalescent.

Remarks.—The typical onset is noteworthy. With regard to typhoid fever in children, it may be said that epistaxis and bronchitis are common, while diarrhœa and rose-spots are often absent. The abdominal symptoms, too, are generally slight. As sequelæ, bone lesions and aphasia are more common in children than in adults. The pleurisy which not uncommonly develops rather insidiously during convalescence is nearly always purulent, but the secondary occurrence of pneumothorax is a very rare accident indeed. Curiously enough, in the only similar case of which Dr. Hale White has personal experience, the pneumothorax developed while the patient, a young adult male, was straining at stool. The delirium of typhoid generally comes on in the second week, as it did in this case, and replaces the headache which rarely outlasts the tenth day. The persistent noisiness of the boy was in strong contrast to his behaviour when convalescent. The sister of the ward, who has had considerable experience of typhoid in boys, has noted that this noisy behaviour is not uncommon.

Thomas T., æt. 64. Four months ago began to have pain in left side of chest. Pain persisted, and was continuous day and night, interfering with sleep. Cough developed and patient lost much in weight and strength.

On admission.—The only thing abnormal, beyond that patient looks worn and wasted, was a small, soft, fluctuating swelling in the middle of, and apparently embedded in, the sternum. There was also a small red patch of dilated vessels above the left nipple. The little swelling was explored with a needle. It bled freely, and on microscopic examination some large suspicious-looking cells were seen. The old man died after he had been in hospital just two months. During this time he grew progressively weaker, and the constant pain was with difficulty controlled by opium. Some fluid collected in the left chest, and the cough became troublesome, with profuse blood-streaked sputum and increasing dyspnœa. Marked tenderness was always present when the front of the chest was palpated at all heavily, and the red patch gradually extended over a large area of the chest-front, and became œdematous. Two days before his death the left arm became very swollen and œdematous. A lump had been previously noted below the left clavicle.

At the autopsy, a small lump of growth was found in the sternum, causing a perforation of the bone. Lungs riddled with nodules, especially the left. Large mass of growth in upper end of left kidney and smaller ones in right kidney and in liver.

Remarks.—The case was thought to be one of mediastinal new growth—either primary or secondary sarcoma of sternum. What are the features of intra-thoracic tumour? Pain, and symptoms of pressure on the thoracic contents—trachea, œsophagus, lung, laryngeal nerve, etc. Our patient had pain, dyspnœa, and, late in disease, œdema of arm from enlarged gland pressing on axillary vein. Is it aneurysm? Age rather late. Absence in history of the aneurysmal tripod, alcohol, syphilis and over-strain. No signs of degeneration in accessible arteries, as radial. No accentuation of aortic second sound.

Why malignant disease? Continuous pain of organic disease, keeping patient awake at night. The progressive and rapid emaciation and weakness. The severe dyspnœa unexplained by auscultatory phenomena, and the sputum freely streaked with blood. Urine, by the way, examined from time to time and found normal. Note absence of deep pressure signs.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	18.	? Appendicitis.
Charity	5.	Scirrhus mammæ.
	13.	Hæmorrhoids.
	14.	Spinal caries.
	21.	Strangulated femoral hernia.

Cases under Mr. Davies-Colley.

Lydia	1.	Necrosis of tibia.
	2.	Extreme deformity of legs; the result of rickets.
	4.	Popliteal abscess.
	18.	Abdominal tumour.
Martha	7.	Varicose veins. Phlebitis and peri-phlebitis.
	17.	Lupus on nose.
	Cot.	Pulpy swelling of knee.
Luke	4.	Talipes equinus. Paralysis of tibialis anticus.

Cases under Mr. Lucas.

Accident 16. Fractured femur.
29. Double Colles' fracture.
42. Compound fracture tibia. Bones wired.
Job Cleft palate.
2. Talipes equino-varus.
21. Strangulated inguinal hernia.
22. Strangulated inguinal hernia.
23. Old injury to head; paresis right hand; giddiness, headache, etc.
25. ? Stone in bladder.

Cases under Mr. Golding-Bird.

Lazarus 13. Chronic abscess over scapula; old tubercular caries of ribs.
22. Congenital funicular hernia.

Cases under Mr. Jacobson.

Naaman 20. Encysted hydrocele of testicle.
21. Epithelioma of lip.

Cases under Mr. Dunn.

Lazarus 1. Fistula in ano.
3. Sarcomatous glands of neck.

The Scientific Diagnosis of Nervous Disease.

V.

"The vulgar fancy that there really is no such science as Medicine, since in these diseases practitioners differ so much amongst themselves."—Hippocrates, *The Management of Acute Diseases*, § 3.

E. Having therefore searched for and excluded Definite Cerebral Disease it remains to exclude a number of conditions the pathology of most of which is still more or less uncertain, and to which for want of a better name the term Indefinite Cerebral Disease may be applied. It is obvious that no hard and fast line can be drawn between these various groups, which overlap and merge into one another.

(α) *Multiple lesions*, as Disseminated sclerosis.
G.P.I.
Widespread arterial disease with widespread softening.
Cerebral tumour in a non-excitable situation.

(β) *So-called Functional disorders*, as Epilepsy.
Athetosis.
Chorea.
Paralysis Agitans.
Migraine.
Infantile Convulsions.
Tetany.
Writer's Cramp.
Tic, Torticollis, etc.

(γ) *Molecular traumatisms*, as "Railway Spine" (brain and cord).
Concussed brain or cord.
Divers' paralysis (cord).

(δ) *Toxæmias*, as Specific Fevers (Anthrax, Rabies, Tetanus, etc. Vascular lesions can generally be traced in Meninges and brain substance, as also in the next condition in one case observed by the writer).
Uræmia.
Diabetes.
Pyæmia (lateral sinus thrombosis, etc.).
Plumbism.
Myxœdema.
Exophthalmic goître (there is reason to think that peripheral neuritis occurs in some cases of this).
Alcoholism, etc.
merging into

(ε) *Mental Disorder* (the test of certifiable insanity is *conduct:* but it is only a matter of arbitrary convenience that disorders of the centres underlying this function or group of functions are placed in asylums, while disorders of less complex centres are treated in accessible hospitals).

(ζ) *The Hysteria group*, closely allied to ε. and termed according to the predominant symptom
Hystero-epilepsy.
Catalepsy.
Hypnosis, Trance and Ecstasy.
Neuromimesis, etc.

With reference to *Disseminated Sclerosis* it is worth while to quote Dr. Buzzard again. "There is a form (of disseminated sclerosis) which is of extreme importance, from the fact that the patient is *for years* regarded as an example of hysteria . . . . . It is not easy to overestimate the number of cases of this kind which are mistaken for examples of hysteria" (*B.M.J.*, October 7th, 1893, and since this article was written, *Lancet*, January 12th, 1895). He has pointed out that in 100 cases of disseminated sclerosis under his care no less than 43 had pallor of the discs (= optic atrophy). In another series of 100 cases Uhthoff found only 48 in whom the fundus was normal, and in 5 of these 48 there was a history of visual trouble. This is treble the frequency with which optic atrophy occurs in *Tabes* (= 24 out of 156 cases, or 15·3 per cent. only).

With reference to *General Paralysis* it is worth noting that the prodromal symptoms may begin in at least four different situations—

(1) Peripheral nerves including special senses (numbness, tingling, retinal hæmorrhages, deafness, etc.)
(2) Spinal cord (tabes).

(3) Brain (apoplectiform or epileptiform seizures, transient aphasia, or progressive defect of articulation).

(4) Intellect (depression, exaltation or simple dementia).

There was a possibility of G.P. in this case, the gait, age, and specific history being in favour of it.

My (ζ) group is so important that I carry it forward and make a special heading of it:—

F. Hysteria, or rather hysteriæ: the most difficult, most Protean, and perhaps the most curable of all nervous diseases. An admirable summary on this subject, on which volumes might be written, will be found in Taylor's *Manual of the Practice of Medicine*. The writer would only point out that *Hysteria* and *Hypochondriasis* have just as much claim to be termed *diseases*, requiring intelligent *sympathetic* treatment as Apoplexy or Intestinal Obstruction; with this difference however, that if suitable treatment can be and is adopted the prognosis in them is a thousand times better. An interesting case of *Hystero-epilepsy* in a man under the care of Dr. Tooth recently came under the writer's notice. The patient was a young postman. His family history included "Hys." in the mother and chorea in a sister, but no insanity. A month ago on receiving news of his father's death he was seized with an 'hysterical fit' (his own phrase), and has since had 5 or 6 of these attacks. He is conscious when a fit is coming on and feels low-spirited. He struggles violently, bites and kicks, so that it required 8 to hold him, and on the last occasion he hurt his thumb in struggling. He thinks the fit lasts 3–5 mins.: at the end of the fit he does not know what is happening, but 5 mins. after he is all right again. He has not wet himself nor bitten his tongue. The attacks have several times come on whilst in the street at night. Of a night he often feels depressed and cannot sleep: he feels as if he would die, and complains of throbbing and palpitation in his left side and neck, also dyspnœa on exertion. He was anæmic, with a rapid pulse, but no sign of organic heart disease. He was recommended to take a holiday.

Mental pain as in Melancholia is probably the hardest to bear of any, and to ignore such a patient's *undisguised misery* and to try and shake him off one's hands as an uninteresting neurotic hypochondriac, as I am certain a good many men would do, simply means that the practitioner has not studied either the functions of the nervous system or the duties of his profession.

The term *hysteria* is loosely applied to almost anything. For example, a patient suffering from typical senile melancholia with delusions was sent up hundreds of miles for treatment in the hospital as 'hysteria.' She was certain she was going to be locked up in a cold cellar underground without even her stockings on, although it was summer. Again, a most worthy and conscientious member of the nursing staff was so depressed by the numerous deaths around her, as to remark that did she not keep her mind well occupied she was sure she would develope "hys." (meaning of course melancholia). So, when the public speak of 'religious mania,' they practically always refer to a melancholia.

Again, what is the term Neurosis to include, or not to include? When the phrase is applied to such remote epiphenomena as *Chlorosis* or *Constipation* (I do not say *incorrectly*), it is clear that it may be applied to any disease under the sun, and hence, having lost all distinct and definite meaning, had better be given up. Functional disease, it has been said, is a cloak for ignorance. It is certain that there is a great deal yet to be learnt about it. That these conditions are well worthy of careful study, it is only necessary to quote Dr. Goodhart to show:—"It is my conviction, forced upon me by the experience of many years, that the maladies which owe their origin to a faulty action of the nervous system are of more frequent occurrence in practice than are even phthisis, heart disease, Bright's disease, or organic hepatic disease" (*Harveian Lectures*, 1891).

In the case under consideration there was no confirmatory evidence of functional disease.

G. Lastly, Malingering (and not, as some would put it, firstly). The case did not, to most people, at first sight suggest this explanation. He firmly refused admission once (the printer inserted the significant little word *was* before *refused* and ignoring the correction in the proof, thus missed the most important point of the whole case): when in the hospital he never once developed "fits" or attempted to "overdo" it as most malingerers generally do; he gave a plausible history and stuck to it. The extraordinary gait, the scattered and anomalous character of the symptoms, the absence of any objective sign of disease beyond the very much exaggerated tendon-jerks, the fact that patient investigation with pins, and hot and cold objects, showed him to occasionally contradict himself, these were the evidences of the real nature of the case. The true diagnosis was made by Time and by Dr. Taylor. He was kept on Milk diet (instead of Chicken) with Mist. Pot. Iod. as a non-stimulating beverage, and made a good recovery in about three weeks. It is possible that the interrupted current might have accelerated matters.

And now, save for some explanatory remarks, the writer's task is ended. His object has not been, as imagined by some, to gain a cheap notoriety by reviling the rightly reverenced heads of his own guides and teachers. Nor, on the other hand, has it been to advertise himself as an inspired specialist in the tiring and tortuous jungle-paths of contemporary neurology. He claims no originality, still less would he claim infallibility. The most valuable of all assistance, is helping others to help themselves, and this is what the writer's object has been. If we are to sneer at Dr. Cortex because he says, *I am for Nervous Diseases*, we ought also to sneer at Dr. Cutis because he says, *I am for everything except Nervous Diseases*. With respect to the caustic remarks of the writer in the introductory article, he would strongly disclaim all personal animus therein. A counsel, who wishes to

build up or demolish a strong case, naturally picks out the facts which either corroborate his own or render improbable his opponent's version and avoids all debateable ground. So the writer purposely strove to place the various fallacies alluded to in the most obviously untenable light. Before constructing a scheme of any kind it is necessary to clear the ground a bit: and, though History does not record the fact, there is little doubt that *Balbus* must have conducted some preliminary operation of this sort before he set about building that wall, which has made his name an household word amongst countless generations of schoolboys. When we hear of a provincial hospital physician diagnosing a case of Spastic Paraplegia as "Atony of the Cord" (whatever that may be), have we any right to return thanks that we are not as other men are, or even as that hospital physician? *Ab uno disce omnes.* The writer is not the keeper of other men's (or women's) consciences and would bitterly regret inflicting gratuitous pain on anyone, last of all on anyone to whom he may be under any personal obligations. He sincerely trusts that this apology will be as a healing balsam unto any whose hearts are said to have been seared by his unguarded caustic points. The situation may best be explained by some memorable words of Dr. Moxon: "It is so difficult for a teacher to remember how he got what he has got, and how long he was about it. Having slowly mastered his own ignorance, he forgets that he must with equal patience struggle with that of others" (*Introductory Lecture* 1868).

Enough has now been said, perhaps more than enough. If one more quotation might be allowed the writer, it would be the words of the Father of Medicine: "I look upon it as being a great part of the art to be able to judge properly of that which has been written. For he that knows and makes a proper use of these things, would appear to me not likely to commit any great mistake in the art." (*Epidemics*, Book III., § 16).

A. J. S.

[Erratum in Article IV., p. 112, column 1, line 11, *for* including Buccinator *read* excluding Buccinator.]

Appointments.

Since our last issue the following vacancies have been filled up:—

Obstetric Ward Clerk.—Mr. B. A. Richmond.

Post-mortem Clerks.—Messrs. C. C. Stead (*May and June*), R. Mathias, F. G. Thomas (*June and July*).

Surgical Ward Clerk.—Mr. B. B. Gough.

Dental Appointment.

Dental House-Surgeon.—Mr. J. Pilcher.

A Case of Osteo-Sarcoma of Lower Jaw.

N. P., æt. 11. Was admitted into Martha, under Mr. Dunn's care, on March 5th, for a hard swelling in the left half of the lower jaw.

The patient is a bright, well-grown, healthy-looking girl, and before the present trouble, has had no illness. She is one of a family of eight, all living and well.

History of the present trouble.—Two years ago she had an abscess, connected with the left side of the maxilla, which "burst," a quantity of matter coming away; the swelling, which only partially subsided, since that time has continued to increase, the rate of growth being more marked in the past few months. There has been no complaint of pain. No teeth have been extracted.

On admission.—There is a marked swelling about the angle of the jaw, extending from the level of the lobe of the left ear to the angle of the mouth. The skin is normal in appearance. Inspection of the mouth shows the lingual side of the gum to be considerably expanded, and a more marked expansion on the outer side of the jaw. The top of this tumour is flattened and little raised above the level of the alveolar margin. The second molar tooth has not been erupted. The first molar and the bicuspids are crowded together anteriorly, and the canines displaced. The gum expanded over the tumour is normal and of a smooth, rounded outline, its greatest transverse diameter measuring two inches.

To the touch, the skin is unattached to the tumour, which is hard and roughly lobulated; it is not tender; no egg-shell crackling can be detected. With the exception of a small spot anteriorly, which is elastic, there is no soft point on it. It is plain that some growth or cyst is expanding the bone, and it can be felt extending up the ramus of the jaw, and from the alveolar to the inferior margin. The whole mass in shape and size may be compared roughly to a Tangerine orange.

There are enlarged hard glands below the jaw on both sides.

The diagnosis presented some difficulty, and the following suggestions were made:—(*a*) A central osteo-sarcoma, expanding the bone, on account of its hardness, and because it affected the ramus. It was, however, objected that two years was a long course for such a tumour. (*b*) A dentigerous cyst, because the second molar had not made its appearance, and on account of the long painless history. (*c*) A chronic osteitis, and this was supported by referring to the original causation, which was inflammatory. (*d*) An ivory osteoma expanding the bone.

On March 16th, Mr. Dunn operated, and made an incision along the margin of the jaw, extending forward from the angle. The skin was turned upwards, and the bone exposed was gouged into; a thin plate of bone was found to cover a solid sarcomatous growth, the incision was therefore enlarged, and the bone fully exposed. The molar and last bicuspid were removed, the mucous membrane divided and sawn through anterior to the

mental foramen. The condyle was disarticulated from the glenoid cavity. The mucous membrane was sewn up so as to shut off the buccal cavity, and then after washing the wound the superficial sutures were inserted.

Progress.—The wound healed without suppuration, and now at the end of the month there is little deformity noticeable, and the patient is able to take solid food. Mr. Newland-Pedley is fitting her with a denture to counteract the tendency of the jaw to fall inwards.

The missing tooth was discovered on the inner side, having perforated the inner wall of the jaw midway between the upper and lower margins, just behind the line of section of the jaw. V. P.

Splenic Anæmia and Splenomegaly with Cirrhosis of the Liver.

The case for diagnosis sent to the Gazette by Mr. Floyd attracted my attention on account of its superficial resemblance to some cases of splenic anæmia, but such an explanation seemed to be negatived by the fact that the spleen could not be felt, and that the thrill in the first left inter-space pointed to some organic disease of the heart. My first idea now appears to have possibly been correct. Anæmia, associated with some enlargement of the spleen, does not appear to me to be so uncommon as text-books would lead one to suppose, but it is only occasionally that we meet with a fatal case. Two such fatal cases have, however, occurred in the Bristol General Hospital during the past eighteen months. In one, the anæmia was comparatively slight, and death occurred, as in Mr. Floyd's case, from what appeared to be erysipelas of the face; in the other, the hæmoglobin was reduced to 17 per cent., and the patient died of the extreme anæmia. Only in the first-mentioned case (where the hæmoglobin stood as high as 45 per cent.) was a post-mortem examination permitted. The spleen weighed 21 ounces, and the suprarenal capsules showed fibroid changes. The liver was considerably enlarged, but since microscopical sections have not yet been cut I am unable to speak definitely of the presence or absence of cirrhosis. In neither of these cases was ascites a marked feature, but Dr. Bonti, of Florence, has described a variety of splenic anæmia which terminates in cirrhosis of the liver. The disease begins with anæmia and enlargement of the spleen, and ends with cirrhosis of the liver and ascites. Of such a disease Mr. Floyd's case seems to me to be a possible instance. The presence of cirrhosis of the liver does not necessarily imply over-indulgence in alcohol. Cirrhosis of the liver has not unfrequently occurred in children where it has been possible to exclude alcohol, syphilis, and tuberculosis as factors in its production, and, if the disease can arise independently of such causes in children, there is no reason why it should not also do so in adults.

Hanot believes that a certain degree of cirrhosis can be set up by toxines absorbed from the intestines in association with chronic dyspepsia, and Dr. Bonti supposes that splenomegaly with cirrhosis of the liver is probably of infective nature, and that micro-organisms of some kind multiply in the spleen and produce toxines that secondarily affect the liver.

Mr. Floyd remarks upon the temperature in his case. Pyrexia, as is well known, is not uncommon in many conditions of anæmia. It was very marked in the more anæmic of the two cases that died in the Bristol General Hospital.

A word or two may be added upon the points that led me to reject the diagnosis of splenic anæmia. One was the fact that although there was dulness in the region of the spleen, that organ could not be felt. The large spleen of ulcerative endocarditis or of typhoid fever may be flaccid enough to escape palpation, but in splenic anæmia the spleen is generally denser than normal, and one would not expect it to be so soft as to be overlooked. More interesting was the condition of the heart. Mr. Floyd lays stress upon the loudness of the cardiac murmurs, but the systolic thrill in the pulmonary area seems to me to be of greater interest. Until the present I have always considered such a thrill absolutely diagnostic of organic disease. One other point may be mentioned in connection with the murmurs. My own experience leads me to believe that Dr. Foxwell's explanation of a pulmonary hæmic murmur is the correct one—namely, that it is due to dilatation of the right side of the heart, mainly in the upward direction. In Mr. Floyd's case there were loud murmurs unassociated with an organic lesion. As is well known, the loudness of such murmurs and the degree of anæmia need not stand in a very definite relation to one another. There may be loud murmurs with slight anæmia, or severe anæmia with comparatively faint murmurs. Accepting for the moment dilatation of the right side of the heart as an explanation for the murmurs, we may suppose that some intrinsic weakness of the heart muscle, either hereditary or acquired as the result of some fever, leads to far greater dilatation in some cases of anæmia than in others. Another explanation may be that the heart muscle in these cases of splenic anæmia does not suffer from the poverty of the blood so much as from the underlying condition, whatever that may be, that is the cause of this poverty.

THEODORE FISHER.

Guy's Hospital Dental Department.

Practice during February, 1895.

Gold Fillings	...	472
Amalgam ,,	...	598
Osteo ,,	...	
Perm. G.P.,,	...	
Regulations	...	5
Artificial Crowns	...	54
Dentures	...	23
Dead Teeth	...	153
Scalings	...	47
Attendance for Extraction under Anæsthetics	...	762
,, ,, without ,,	...	354
Total	...	2468

A Case of Hæmoglobinuria.

W. J., a collier, married, with four children. Family history and previous medical history unimportant.

I first saw patient in the early part of November, 1894, and treated him for a carbuncle on his thigh. In the beginning of December I again saw him, and treated him for pediculi corporis.

On December 18th, he sent down to the surgery a bottle of porter-coloured fluid, with a message to the effect that he felt very ill and had passed the fluid on micturition.

On examination, the fluid had a specific gravity of 1020, was acid in reaction, and contained a quantity of albumin. Not having a microscope at hand, the fluid was not subjected to this examination, but I concluded that the man had nephritis, and sent him up Pulv. Jalapæ Co. gr.xl. Next day I visited him and found him looking considerably paler than usual, and complaining of lumbar pain. He had no œdema; his pulse was soft, regular, and only slightly quicker than normal. Heart sounds normal.

The water he was then passing was much paler than that examined the night before.

I told him to stay in bed, and to take milk only for food, and sent him up medicine containing Pot. Bicarb. Pot. Nit. and Liq. Ammoniæ Acetat.

In three days the urine was quite clear and free from albumin. As I began to doubt my diagnosis and he seemed so much better, I allowed him to get up at the end of a week, and he went back to work on January 7th, 1895. On the evening of January 9th, another bottle of porter-coloured fluid was sent down to me with a message that he was ill again in the same way. This time a more complete examination was made and no blood corpuscles could be seen under the microscope. There were a few granular casts, oxalates, crystals and a quantity of granular débris.

On questioning him next day, I ascertained that he had been working on the coal-tips on the side of the mountain, exposed to a cold east wind, and standing all the time in half a foot of snow. He had felt it very cold and his hands and feet became quite numbed. He went home shivering and was taken with great pain in his back. On micturating shortly after he passed this porter-coloured fluid which rather relieved the pain in his back. He was given the same mixture containing Pot. Bicarb., Pot. Nitrat, and Liq. Ammon. Acetatis, and kept in bed for a few days, but allowed ordinary diet. Two days later he was again passing clear, albumin-free urine, but had still some pain across the lumbar region.

I prescribed Tinct. Ferri. Perchlor., Mag Sulph. and Aq. Cholorformi, and allowed him to go back to work on January 26th, after cautioning him about getting exposed to the cold and advising him to get work underground if possible. This he did, and when I saw him last on February 26th, he had had no further trouble with his urine. He still had a little pain across the lumbar region.

J. S.

From the Gazette's Special Pathologist.

All specimens — particularly those of solid tissues — should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

H. C., Stockwell.—There is no appearance of inflammation in any of the section of the nerve examined. Portions of the nerves were teazed out in osmic acid immediately on receipt, to ascertain if any of the degenerative changes described by Sidney Martin could be seen. We are afraid, however, that no definite opinion can be given, as the nerves already showed signs of microscopic post-mortem changes.

J. H. D., Port Talbot.—Tubercle bacilli are present in considerable numbers in the sputum.

G. W. K., Battle.—No bacillus diphtheriæ could be found either in the membrane or on the cultivation.

A. C. B., Dorking.—The spores and hyphæ of the tinea tonsurans are present in the hair-roots.

W. A. E. W., Rugby.—Tubercle bacilli are present in small numbers.

J. H. P., Bampton.—Tubercle bacilli are present in fair numbers.

H. B., Dulwich Village.—*Micros.* A slight excess of leucocytes, but no casts of any kind.

I. L., Farnham.—We are unable to understand the examination of water sent up. Please send us your full address that we may communicate with you.

H. L. W., Salisbury.—The fragment of growth consists of a cylindrical-celled carcinoma invading the muscular coat of the rectum. Parts of it have undergone colloid degeneration.

F. R. B. B., Tunbridge Wells.—The pus contained no tubercle bacilli, and the sediment, after centrifugalizing, consisted of pus cells and squamous epithelial cells.

W. C. B., Bognor.—A fairly large number of tubercle bacilli are present in the sputum.

G. H. M., Clare.—The culture yields a crop of whitish colonies suggestive of diphtheria. On microscopic examination, there are found present (1) Bacillus diphtheriæ; (2) Streptococci; (3) Staphylococci; (4) Certain other bacteria.

PATHOLOGIST.

Passim.

The Hospital is poorer by the loss of four old Residents. Messrs. R. H. Fagge, H. A. Duffett, H. M. Stewart and L. Slater are the gentlemen whose passing was celebrated at the "going-off" dinner, held in the Club dining-hall, on Saturday, March 30th. The uproariously hearty manner in which they and their speeches were received on that occasion was but index of the feeling which has prevailed towards them during their stay at the Hospital, and particularly during the time that they have severally held the higher appointments. "For he's a jolly good fellow" is the sentiment which we would most heartily echo concerning each one of them.

It is to be regretted that the healthful and harmless game of quoits cannot be indulged in within the precincts of the Park. For why? The ground is being dug up that the sparse growth, which a London-trained mind allows itself to call grass, may have place. Surely a little space might be reclaimed from this jungle.

A notable operation has within the past fortnight been performed within the walls of Guy's. Removal of the Casserian ganglion for neuralgia, of so obstinate a character as to render life scarcely endurable, is an operation of sufficient rarity to warrant at least a passing notice. At the time of going to press, the patient was progressing favourably.

We should congratulate the Association XI. on their good fight with Bart's. Their pluck was especially commendable after the loss at the eleventh hour of two prominent members of the team. The "Rötheln" which deprived us of Mandy's services, gave K. B. Alexander a chance to accomplish a record—and well he used it—of being a member of the Cricket, and both Footer teams for the year. We believe no player except W. G. Mitchell has accomplished this at Guy's. We hear now of a strange coincidence, viz., that Alexander has himself been laid by with the complaint which gave him his last "Blue."

The Gazette's Special Wanderer, who goeth to and fro on the face of the earth, seeing things beyond the ken of average mortals, has happened upon a Spirit of Destruction at present at large, to the danger of the common weal, in the College. It was in the Wanderer's note that this same spirit, or demon, doth occasionally possess himself of a man, who straightway breaks a piece of furniture. Among casualties so produced are listed a punctured fracture of the Charitable Portal, and a compound fracture of the arm-chair in the same department, besides much rending of the air with horrid din. How best to expurgate this demon is the question, for the dignity of behaviour proper to residents being brought so low, 'tis feared that those of the baser sort, and less advanced in years will be less mindful of their ways, and Portal luxation and Ginglymotripsy will become yet more common.

We learn with pleasure that in the recent Conjoint Examination, 41 men passed in "bones" out of a total of 49 candidates. The Biology results were almost equally happy. Demonstrators and students are alike to be congratulated on such good work.

A recent number of *Invention* says—"A new process for identifying handwriting is claimed to have been discovered by Dr. Bertillon. It is based on the measurements of the beatings of the pulse, which, he says, have in everybody a different and thoroughly characteristic effect on the handwriting. The handwriting, or presumably, negatives of it, are enlarged till the letters are a foot high, and then the characteristic marks are easily observed." How's that for high?

Lieutenant-Colonel G. C. Hall, F.R.C.S., England, whose remarkable Ophthalmic exploits find a place in the pages of last week's *Lancet*, is a Guy's man. We imagine that 147 operations in six days, would make the eye-dressers feel in need of a holiday. The natives of Oudh would seem to be peculiarly under the influence of the Evil Eye.

Mr. F. J. Steward allows us but short rest in our congratulations, which seem now to have taken on an intermittent type. This time the Beaney Prize for Pathology makes him the subject of our felicitations. We also tender congratulations to Mr. F. E. Walker, the winner of the Michael Harris Anatomy Prize, and to Mr. H. W. Bruce, who came a good second.

The Librarian desires to acknowledge receipt of 10s. anonymous, 7s. 6d. from Dr. Lawford Knaggs, and 5s. from Dr. George Black, towards the "Parsons" Testimonial Fund.

Mr. Christopher Heath has been elected President of the Royal College of Surgeons for the remainder of the Collegiate year, in the vacancy caused by the death of Mr. J. W. Hulke. During the last few years St. Bartholomew's, London, Guy's, Middlesex, and now University College have in turn supplied the President of the College.

The General Medical Council have appointed Mr. Charles Tomes as Visitor of the Dental Examinations of the College of Surgeons. Accordingly he will visit and inspect these examinations during the present year.

Mr. H. J. Waring, of St. Bartholomew's, has gained the Jacksonian prize for his essay on "The Diagnosis and Surgical Treatment of Diseases of the Liver, Gall-bladder, and Biliary Ducts."

H. A. C. Smoking Concert.

A Football Match and Smoking Concert in aid of the funds of Guy's Hospital took place at the Head-quarters of the Honourable Artillery Company, Finsbury, on the 3rd instant. It should be explained that the football club of this ancient regiment has with rare generosity annually devoted the proceeds of a similar match and concert to some charity. This year, through the good offices of Mr. Michael, Guy's is to be the fortunate recipient, and it is gratifying to learn that the present occasion has surpassed preceding ones in every way.

The match was played in the afternoon, an interesting game resulting in a win for the Hospital team. Afterwards, the teams dined together, and at 7.30 the smoking concert was commenced in the Drill Hall before a packed audience; and the entertainment continued in full vigour until 12.30. Among the 53 artistes whose names appear on the programme, we may note the names of Messrs. Harry Randall, R. G. Knowles and John Le Hay, and the Misses Marie Lloyd, Lilian Alexander, Billy Barlow, Katie James, Maggie Duggan, Katie Lawrence, and Minnie Cunningham. At the interval the chairman, Captain Evans, who presided in the absence of Colonel The Earl of Denbigh, made a capital speech on behalf of charities in general, and Guy's in particular, after which collecting boxes were sent round, the contributions amounting to £35. To this will have to be added the proceeds from sale of tickets, so that it is probable the Hospital will benefit by a very handsome amount. In thanking all those who helped to make the occasion such a pronounced success, Mr. W. S. Gofton, Vice-Captain of the H.A.C. Football Club is to be congratulated upon his excellent stage management.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Nurses' "Extension Bill."

Dear Sir,—"The Governors have sanctioned the following scale for the extension of Nurses' and Probationers' annual holidays, viz.:—At the end of

1 year	2 weeks.
2 years	3 weeks.
3 and following years...	4 weeks.

(Signed) Florence Nott-Bower,
Matron."

So read the announcement on the notice-board outside the dining-hall door, and seldom indeed has any notice been received with such acclamation.

Half an hour before the notice-board had been empty. The pass list of the last examination had been removed—very much, doubtless, to the joy of those who were unfortunate enough to find their names dangerously near the bottom of the list. Now it was replaced by the magic words given above, which were read and re-read delightedly by an eager and ever-increasing crowd.

It was the nurses' dinner-hour, and with somewhat jaded and weary looks the busy workers had hurried down to recruit exhausted nature, after some hours of manifold labours in the wards, and, glancing at the notice-board for a moment before entering the dining-hall, one after another devoured the welcome words that meant so much to each.

The sudden change in the expression of their faces was good to see. Care and tiredness rolled back to give place to sunny contentment and the best looks of which each face was capable.

"Hooray! That's the very best notice that ever was up!" said one.

"How awfully jolly!" cried another.

"Whose doing is it?" enquired a third.

Back we went to the wards, refreshed and strengthened by something besides our dinner, and I am sure the patients distinctly benefited in a most direct manner that afternoon by the added brightness of our faces.

"Extension!"

I think one wants to be a nurse to understand fully all that our holiday means to us.

The long anticipation—the saving and planning—the consideration of ways and means—the uncertainty, whether at the last moment something may occur to prevent our going after all—these things sharpen considerably the edge of our longing, and make us count the time to our holidays more eagerly than ever we did in our boarding-school days.

Don't think we do not love our work because we are so glad to leave it for awhile. We do; and the majority of us enter hospital life with a sincere desire to do good, and serve others to the best of our ability.

But we all get weary sometimes; and everyone who has seen anything of nursing knows what a very trying life it is, and how all things seem to combine to take the vitality out of us.

The monotony of the work—the fractiousness of the patients—the uncongeniality, sometimes, of surroundings, and hundreds of the other small items which go to make the sum-total of a nurse's life—these all soon cause us to sigh for holidays and some quiet nook "far from the busy haunts of men."

To have our needs realized and met by those in authority is delightful; and though it has been remarked that those whom we seek to benefit are often the last to appreciate the efforts made to do them good, we nurses of Guy's Hospital assure everybody that we do appreciate all that has been and is being done on our behalf.

We welcome every change for the better in our midst, and know that we shall be doubly loyal to our Hospital and do better work for each concession that is made to us.

Co-operation is better than coercion, and privileges than penalties. That is just what the Nurses think about it, and I believe in saying so I am but echoing the voice of all, for I speak not without knowledge of the subject, being ONE OF THEM.

Specialism in Medicine.

Dear Sir,—I am sorry to have given Dr. Fisher the impression, if I did so, that it was narrow-minded to investigate a particular disease, or group of diseases; there was no such intention on my part. I quite agree with Dr. Fisher that it is dangerous for a man to announce himself as specially proficient in the treatment of a particular class of disease, but that there existed any group of diseases to which anyone, not a specialist, had given "little thought" I certainly was not aware.

In the next paragraph my ideas are entirely misinterpreted. I am decidedly of opinion that no one gains a place on our junior staff who is not perfectly competent to teach students as suggested, viz., by taking case after case and demonstrating the essential derangement of health; but how would this prevent the surgeon from showing us how to operate in the theatre and from giving clinical instruction in the surgical wards. It would merely delay for a few years the entire differentiation of surgeon and physician, and this I hold would be a distinct gain to both teacher and student.

Prognosis is clearly a matter of experience almost exclusively. Dr. Fisher's distinction between diagnosis and etiology strikes me as very flimsy. I defined diagnosis as the tracing of a disease to its ultimate cause; the mere labelling of complaints as eczema, psoriasis, etc., does not, to my mind, deserve the name of diagnosis. It was this habit of labelling and shelving instead of diagnosing that made Dr. Moxon declare that a disease ought not to be named at all, if possible, and that when a name must be given it ought to be carefully chosen so as to mean nothing.

On the subject of cramming, Dr. Fisher is apparently quite orthodox, but his remarks do not surely bear on the matter in hand; in fact, so far, a number of straw men have been demolished, but they were not, so far as I know, of my manufacture.

In his closing paragraph, Dr. Fisher confines himself entirely to what I understand controversialists call "unsupported assertion." Monotony and want of variety were surely unfortunate terms to apply to my ideal out-patient rooms. Medical and surgical out-patients have never proved monotonous to my knowledge, and how they, combined, would be rendered so by the addition of an occasional throat, eye, ear, tooth, etc., I cannot see.

For dull unmitigated monotony commend me to an afternoon spent with a pot of vaseline and a basket of pessaries, or a 12 to 6 sitting of unadulterated spectacles, or hours spent in an unvaried series of "Extractions."

I am sorry the question should have been so directly raised of the comparative merits of a staff of specialists and their teaching, and a staff of my more natural selection. My opinion is, of course, directly opposed to Dr. Fisher's. Is it possible by any conceivable system, or want of system, to provide a staff of "One common level of uniform and universal interest?"

Rhetoric, not reason, I am afraid, guided Dr. Fisher. In closing, Bright, Addison, Cooper, Moxon, and their worthy successors of our day, do not rise above mediocrity in consequence of any particular system of our devising; our great men are, like other great people, born, not made. The men selected for my ideal staff would all enter it by the front door; and how the opening of more and more, smaller and smaller, side doors is to secure teachers of greater reputation is a problem that I gladly leave for solution to Dr. Fisher.—Yours, etc.,

S. W. MacILWAINE.

[This correspondence must now cease.—Ed.]

Reviews.

A Students' Text-Book of Botany. By Sydney H. Vines, M.A., D.Sc., F.R.S., Sherardian Professor of Botany in the University of Oxford (Swan Sonnenschein & Co., London). Price 15s.

This long looked for volume will be warmly welcomed by all students of Botany. A book, which although not too long for the general student, yet includes the most recent work upon the subject, has been much wanted, and we can congratulate the author upon having so ably supplied this need. The most interesting, and at the same time the most important chapters in the book, are those dealing with the cell as a unit, and with the various fascinating questions included under the heading of plant physiology. The illustrations, although for the most part familiar, yet include a considerable number of new figures.

The Urine in Health and Disease, and Urinary Analysis Physiologically and Pathologically Considered. By D. Campbell Black, M.D., Professor of Physiology in

Anderson's College Medical School, Glasgow (Bailliere, Tyndall & Co., London). Price 7s. 6d.

This little book upon the subject of urine in health and disease, will be found of more value as a book of reference than as a text-book. The facts contained in the volume are very numerous, but they cannot be said to be well classified, and might with advantage be sifted to a considerable extent. By this means the book would be rendered decidedly more useful. A more serious objection, however, is that the methods recommended are not always either the most recent or the best; for instance, under the head of uric acid, Hopkins' method is not mentioned, whilst the older and less reliable methods are described at some detail. However, in very many respects the book is a good one, and will certainly be of the greatest service to those who are desirous of performing the more ordinary urinary analyses and examinations.

A Course of Elementary Practical Bacteriology. By A. A. Kanthack, M.D., and J. H. Drysdale, M.B. (Macmillan & Co., London.) Price 4s.

This is an exceedingly useful little book, containing short, clear and precise descriptions of various methods of cultivating and examining Bacteria, of isolating the products of their growth, as well as directions for the bacteriological examination of water and air. The book can be most warmly recommended to all who are engaged in the study of Bacteriology.

Examination Papers.

MICHAEL HARRIS PRIZE.

I.

1. Describe the Cuboid and Os Magnum. 2. Give the position, branches, and connections of the Otic, and of Meckel's Ganglion. 3. Give the position of the Heart and of its valves relative to the chest wall. Describe the coronary arteries and veins. 4. Give the origin, insertion, and nerve-supply of the muscles of the third layer in the sole of the foot. 5. What are the relations of the Male Bladder? State the changes which take place in its position and shape dependent on age or contents. 6. Give the course, relations and branches of the Vertebral Artery.

II.

1. How would you expose the Sub-Occipital Triangle? Give its boundaries and contents. 2. Describe the course and relations of the Arteries which enter Cranial Cavity, limiting your description to the inside of the Skull. [The Vertebral Artery is not included in the above]. 3. What anatomical arrangements exist for neutralising the effect on the Brain and Spinal Cord of shocks, when we jump from a height on to our feet. Describe how these arrangements act. 4. Enumerate in their order and describe briefly the structures which are met with on the floor of the fourth Ventricle. 5. What are the uses of the following:—Fascia Lata; Ischio-Femoral Ligament; Interosseous Ligament of the Forearm; Ligamentum Posticum of Winslow? 6. Enumerate the structures which would be met with in dissecting from the surface to the perinæal aspect of the Prostate Gland. Describe carefully the muscles.

The Prize awarded to Mr. F. E. Walker. Mr. H. W. Bruce, proxime accessit.

BEANEY PRIZE IN PATHOLOGY.

I.

1. Describe fully the pathological changes that take place in the various forms of intussusception. 2. What are the various causes productive of high arterial tension, and to what structural changes in the body may they give rise? 3. Describe the pathology of the various forms of tuberculous tenosynovitis. 4. Classify the conditions which induce clotting in the blood-vessels during life. Name the vessels in which this is most liable to occur, and give the most frequent causes corresponding to the respective vessels. 5. Describe the several conditions which may arise from the presence of gall-stones. 6. Discuss the pathology and causation of vertigo.

II.

Practical Work.—1. Naked-eye Specimens.—Rickety femur from an elderly woman. Hydatid of Liver perforating Diaphragm. Littré's Hernia. Horse-shoe Kidney with calculi. Heart showing fibroid degeneration of Endocardium. 2. Histological Specimens.—Myeloid Sarcoma. Carcinoma Testis. Thickened Pleura with normal Lung. Broncho-Pneumonia. Wart. Cystic Kidney.

Winner of Beaney Prize, Mr. F. J. Steward, M.B., B.S.

Appointments.

Alexander, S. R., M.B. Lond., M.R.C.S., has been appointed Medical Officer for the First Sanitary District of the Faversham Union.

Still, Geo. F., M.A., M.B., Cantab., has been appointed Medical Registrar and Pathologist to the Hospital for Sick Children, Great Ormond Street, Bloomsbury, London.

Watson, William, M.R.C.S., Eng., L.S.A., has been re-appointed Medical Officer of Health to the Rochester Town Council.

"Jam Jam non Satis."—A nurse, when asked by her chief a few days since, if she understood how to give a suppository, replied with the greatest confidence—"Oh, certainly, sister, but we haven't got any more jam."

[This is perfectly true, but *not* of Guy's.—Ed.]

NOTICE TO CORRESPONDENTS.

The Editors wish it to be understood no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Guy's Hospital Trained Nurses' Institution.

We have received from Sister Sarah the following Tenth Annual Report of this Institution, part of which we reprint in full:—

In submitting his Annual Report for 1894, the Treasurer has to express the satisfaction of the Trustees of the Institution that, in a year which has been characterised in general by a slackened demand for Nurses, the Private Nursing Staff of Guy's has been so highly appreciated by the public as to have received 1,012 applications for assistance, the applications exceeding by 180 the actual number of cases which it was found possible to attend.

The number of Nurses employed during the year has varied between 82 and 85, nor has the difficulty of providing temporary accommodation for them in the Institution, when they have not been engaged at a case, at any time proved acute, though, as was stated in the Report of last year, it is much to be desired that more sleeping room were available. Something, however, has been done in this direction by securing the use of a spare bedroom, at a small rental, in the Hostel, in which two or three nurses can be placed, should the space in the Institution be fully occupied.

The fees received for Nurses' services have risen from £5,057 in 1893 to £5,917 in 1894, and the salaries from £2,248 to £2,891. The expenditure on housekeeping has declined from £376 to £286, on uniforms from £418 to £262, on sundries from £151 to £91. An increase of expense has, however, to be recorded under the head of furniture, repairs, stationery, and advertising, so that the total expenditure of the year reaches £4,590, as against £4,530 in the previous year.

The Secretary of the Royal National Pension Fund for Nurses has been good enough to supply the Treasurer with exact figures showing the amount already invested up to the present date in the Fund by the Nurses, and by the Institution on behalf of the Nurses, for policies now in existence, the former sums being paid quarterly in respect of a pension of £7 10s. per annum, and the latter for a pension of £11 5s. at the age of 50 years. The figures are as follows:—

Total amount received from Guy's Nursing Institution in part payment of *Policies in existence*, taken out on behalf of the Staff					£694	14	1
Nurses' payments under the same Policies					475	2	6
					1,169	16	7
Bonus, 1894	...	...	£145	0 0			
„ 1895	...	...	500	0 0			
					645	0	0
Trust Fund	...	...			390	1	8
					£2,204	18	3

In last year's Report the Treasurer gave an outline of the Bonus Scheme by which the profits of the Institution are divided at the end of the year amongst the Nurses of standing to participate according to a scale, which was given in detail. The Treasurer is glad to say that the scheme has met with very general approval, and has without doubt attracted to the Institution the patronage of medical men throughout the country, who desire that the principle of profit-sharing should receive a wider application in Nursing Institutions, and that the Nurses employed in private work should have their earnings equitably divided amongst themselves in such a way as to afford due provision for a time of life when they may be unequal to the arduous and trying work of their profession.

An inspection of the Balance-sheet shows that the Institution has now £1,000 in hand as a reserve to meet any unexpected emergency, having during the past year added £250 to this account; that the annual payments, bonus, and trust monies contributed to the Pension Fund last year amounted to £813; and that the balance at the Bankers at the end of the year was £722. The profits have accordingly been such as to allow a bonus division at the rate of £10 a share as against £5 last year, and the sum required for this division amounts to £500. It may be well to mention that the Nurses of longest standing thus obtain a bonus of £80 in the year, exclusive of their ordinary salaries of £40, whilst those who have been five years in the service of the Institution, and thus have become eligible for the lowest number of shares in the Bonus Fund, receive a bonus of £40, the shares of the other Nurses varying between these two figures.

During the past year the two Maternity Nurses, who are maintained at the cost of the Institution, have attended 299 cases, and paid 3,216 visits in the district embraced by the Lying-In Charity of Guy's Hospital. The following table shows the number of cases attended in each Parish within that area:—

Name of Parish.	Number of cases.
St. George's Southwark	80
Parish Church, Bermondsey	64
Christ Church, Bermondsey	30
St. Saviour's, Southwark	24
St. Mary's, Newington	19
St. John's, Horselydown	17
St. Alphege, Southwark	16
St. James's, Bermondsey	14
St. Olave's	10
St. Paul's, Nelson Street	10
Christ Church, Southwark	7
All Hallows, Southwark	4
Trinity Church, Trinity Square	4
	299

The Treasurer is glad to remark that the subscriptions to the Maternity Samaritan Fund, amounting to £45 19s. 6d., are maintained a little above the level of last year. The object of this Fund, it may be explained, is to provide clothing, food, coals, and other necessaries and medical comforts for destitute mothers at the time

of confinement. The extreme poverty of the South-east district of London has now become pretty generally known, and, as shown by Mr. Charles Booth, there is no part of London with so large a proportion of poor and indigent persons in it. The Treasurer, therefore, ventures to appeal for continued support to this good object, and as relief is only given to cases of which the Lady Superintendent and the Maternity Nurses have full cognisance, those who contribute to the Fund may rest assured that their gifts will be disposed of to the best advantage, and will not pauperise the recipients.

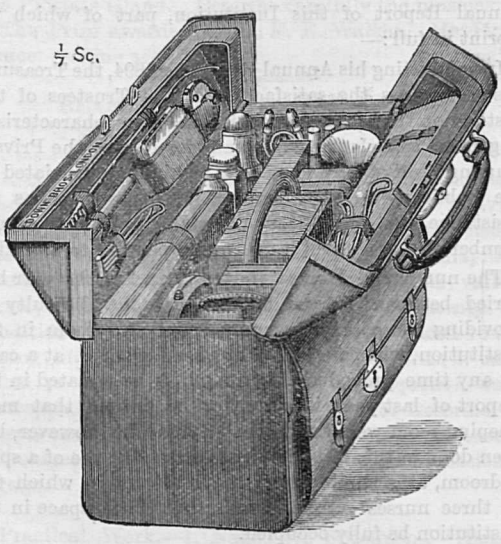
The following is the list of last year's donations and subscriptions :—

	£	s.	d.
Samaritan Fund	10	0	0
The Residents of Guy's Hospital, Surplus from Dance	9	11	7
Collections in Hospital Chapel	4	18	5
Oswald Smith, Esq.	3	3	0
Messrs. Barron	2	2	0
Mrs. Phillips...	2	2	0
Mrs. Swift	2	2	0
Dr. E. W. Goodall	2	2	0
H. Ablit, Esq.	2	2	0
J. Sherwood, Esq.	1	1	0
H. Ablit, Esq. (Second Donation) ...	1	1	0
Miss Cotton	1	0	0
Dr. Perry	1	0	0
Mrs. Sturt	1	0	0
Mrs. Every-Clayton...	0	10	0
Miss James	0	10	0
Mrs. Hunt	0	5	0
Sister Mary	0	5	0
Miss Wilson	0	5	0
Miss Taylor	0	5	0
Sister Job	0	5	0
Miss Fricker	0	5	0
Miss Lushington	0	3	0
Master Georgie Gillett	0	1	6
	£45	19	6

Gifts of clothing and bed-linen (new and old) have been received from Mrs. Burford, Mrs. Sturt, Miss Fricker, Miss Strang, Mrs. Hickson, Mrs. Harvey, H. Senior, Esq., Mrs. Bligh, Sister Naaman, Miss Dawe, Nurse Steer, Mrs. Hamilton, The Dowager Lady Vernon, Mrs. Hayhoe, Mrs. Durham, Mrs. Perry, Sister Clinical, Nurse Marler, Mrs. Blagg, Mrs. Shaw, A Work Society in Upper Clapton, Sister Philip, Mrs. Friedlander, Sister Job, Miss Cumberland, The Misses Jones, Sister Cornelius, Miss Preller, Sister Bright, Nurse Pearce, Nurse Buckton, Lady Hartford, Miss Grahame, Nurse Baker, Messrs. Swan and Edgar, Nurse B. Gracesmith, Miss James, Mrs. Meekin, Miss Baker, Nurse Collins, Miss Wilkinson, Mrs. Anderson, Nurse Flude, Nurse Mills, Mrs. Hunt, Sister Dorcas, Sister Luke, "W.," in answer to appeal in the Guy's Hospital Gazette, Mrs. Goss, Mrs. S. Lushington, Nurse Harvey, Nurse Todd, Mrs. Watson.

Notices.

A NEW DIAGNOSTIC AND EMERGENCY BAG.



The above illustration shows a bag which has been designed at the suggestion of Mr. Arbuthnot Lane to meet all the requirements of general diagnosis and of ordinary surgical emergencies.

The contents of the bag include: specula for the nose, ear, vagina and rectum, laryngoscope, tongue depressor, rhinoscope, ophthalmoscope, and ophthalmic discs, as well as a small accumulator fitted with an electric search light for forehead use. Clinical thermometer, binaural stethoscope, steel tape measure, complete urine test case, exploring aspirator, uterine sound and various probes. Pellets for making antiseptic solutions, an antiseptic lubricant, ordinary surgical pocket case, chloroform drop bottle, nitrate of amyl capsules, cocaine pellets for local anæsthesia, and a hypodermic syringe in case with tabloids for making the solutions: most of the instruments being placed in separate cases, so that they can be removed and carried separately when desired. When full, there is still sufficient room in the bag to accomodate a few dressings. The bag itself is of a convenient size, measuring 15 by 8 by 10 inches, and can be supplied either complete, empty, or partially fitted, as may be desired. We feel confident the bag will be found to meet a very general want: it will enable the student to carry readily every ordinary and diagnostic instrument, and so avail himself of every opportunity of accustoming himself to the use of the instruments of his own choice. The practitioner will also doubtless appreciate a simple and convenient bag containing every necessary instrument for diagnostic and emergency work.

The makers of this bag are Down Bros., St. Thomas's Street, London, S.E.

THE STANDARD MALT EXTRACT.

Extract of malt is an evaporated infusion of malt. Taken with food its diastase aids in the conversion of starch into the variety of sugar termed maltose, and dextrine, and hence it assists enfeebled digestive powers. The consumption of malt extract at the present time is very great, and there is no doubt but that this fact is an indication of its great value as a digestive agent. The preparation of the extract requires the greatest care, and a satisfactory product can only be obtained by the use of special apparatus. It is well known that diastase begins to lose its digestive power at a temperature of 150° F.; that degree should not be exceeded in evaporating the infusion of malt; indeed, if the dissolved albuminoid matters are to be retained, the evaporation should be conducted at 120° F.

The value of an extract of malt, is determined by an estimation of its diastasic power. The following is the method in general use; 1·5 grains of the extract is dissolved in 15 c.c. of water, and mixed with a mucilage of ·1 gram of starch, in 100 c.c. of water. The mixture is raised to 140° F., and tested from time to time, by adding two drops of iodine solution to 5 c.c. of it, and comparing with 5 c.c. of a similar mixture, to which no starch has been added. No difference of tint between the two solutions indicates completion of the reaction. A very good extract will accomplish this within half-an-hour, but many commercial extracts will not do so until nearly three hours have elapsed.

We have examined by the above process, a sample of Malt Extract sent by the Standard Malt Extract Company, Limited, 23, Billiter Street, E.C., and find that it is capable of converting the standard quantity of starch well within the half-hour.

We can say that the Standard Malt Extract possesses a very high diastasic power, and that it can be recommended to prescribers as a very agreeable and perfectly reliable preparation.

From the Smoking Room.

Our friends the Pundits were discussing "Patriotism" —the patriotism of a Borough denomination whose members are of many shades. Theophrastus Such, "man of many silences and much suspense," had first and in an inspired moment passed the phrase. The haziness suiting indefinable ideals in the sect was adopted, and will stand. It so inaccurately describes many differences and much looseness of thought when one wearies of the sentiment at the repetition. There is even poetry in it, although one of the Pundits—an admirer of the American "tramp and idler," Whitman, —has told me that "patriotism" is the prose equivalent of the phrase "in true Guyite fashion" (a phrase much abused at gatherings of the Borough sect). They discussed the sentiment with no "marvellous tact of omission," Theophrastus alone being silent. To whom it was a fact for use in motive power,

"Patriotism," quoted one, "is the last refuge of a scoundrel." The appointment list was just out.

Our Utilitarian denounced the sentiment from hill to valley, and instanced cases. He has no mercy for the ideal which is outside him.

"It is so diffuse," put in Parmenides.

"I use it as an Economy."

"For appointments?" An office-seeker had spoken.

"For disappointments."

"It is so very relative," pursued the Platonist.

"And quite weird," quoth the Pagan.

"Rather inadequate, I fancy," came the reply.

"It kindles sentiment," urged an Optimist.

"And might yet be more lucid," from the Parmenides.

"Adhesive yet hardly coherent," said Theophrastus, breaking silence on the light of the idea.

"Anyhow, it's SPORTSMANLIKE," sneered the Saphoist.

"Now, touching the relativity and application of that last phrase among us, I observe ——," began Dun Scotus.

But my head ached, and I fled. Fortunately the Pundits meet but once a fortnight. Otherwise—— "But that is quite another story."

DIDEROT.

The Medicine of the Future.

It has for some time past been suspected that the pseudo-homœopathic treatment of diseases by animal extracts, derived from organs corresponding to those supposed to be the seat of the morbid process, was being overdone. Whether the appended letter confirms or annuls this suspicion, let each one judge for himself.

LUNEHAM, *Feb. 21st, 1895.*

DEAR SIR,—The enclosed advertisement of my Extractum Mentis may possess some interest from the fact that it was written *a year ago*. I felt, however, that medicine had not advanced sufficiently to make such a preparation a commercial success, so I deferred putting it on the market for a few years longer. Sir, I underestimated the rapidity with which science now advances. Judge of my surprise at seeing an exactly similar extract advertised in one of your recent issues. It is not pleasant to lose the priority of one's discovery in this way, but I am now incubating an Extractum Nervi Auditorii which will undoubtedly *make deafness a thing of the past*. Not a word of this.—Yours, confidentially,

COLNEY HATCH, B.F.

Extractum Mentis Concentratum.

Prepared from the cerebra of selected calves by a new physico-psychical process. This Extract will be found by the Profession at large *invaluable* for persons of weak intellect, and for those preparing for the Higher Examinations.

Its special merits are:—

1. The higher centres only are used in its manufacture.

2. The mental condition of the animals from which it is obtained is carefully tested, and those unable to distinguish between limewash and London milk are rejected.

3. It has been analysed by the Psychical Research Society, and is found to contain 10% of Pure Intellect.

Read the plain facts:—

"Ten Years' Examinee at the Royal College of Surgeons" writes:—"Since using your Ext. Mentis I find that I require a hat two sizes larger than previously. Need I say more?"

Hy. Drokefalus, Esq., says:—"Since I began to take your preparation the density of my cortex has increased so largely that my centre of gravity has moved upward six inches. I can now stand on my head under water without difficulty."

Spread on bread and butter it makes an excellent substitute for marmalade.

Children like it, and become infant prodigies.

Ask for *Extractum Mentis Concentratum.*

Sport.

Association Football.

INTER-HOSPITAL CUP FINAL.

GUY'S v. ST. BARTHOLOMEW'S.

Played at Leyton on the 25th March, before a large number of spectators.

The weather was fine, but there was a regular gale blowing, which rendered accurate play impossible. The game was of the kick and rush description, there being scarcely any combination, and what little there was fell to the lot of the Bart's forwards.

The ill-fortune which has accompanied our team during the season, did not intend to forsake us in this important match, for almost at the last moment, we had to enter the field without Cooper and Mandy, on account of injury and illness. We had to call upon the services of Swan and Alexander, the latter, though a member of the Rugby XV., filled the place of outside right forward with great credit, considering he had never before played in that position, and in fact he made the two best single-handed runs of the day.

Humphry, though he turned out, was also on the injured list, having strained a muscle in his left leg, and so was unable to take advantage of one or two good openings for want of pace.

Fitz-Hugh having won the toss, elected to play with the wind at his back, and Bart's kicked off a few minutes after advertised time. Guy's at once took up the attack, but were unable to break through their opponents' defence. Many good opportunities for scoring presented themselves, but the shooting was feeble in the extreme right through the game, and what shots did go near the goal, were well stopped by Fox.

Bart's broke away on two or three occasions, but were unable to take advantage of them from the same fault of weak shooting; in fact Willet had the goal at his mercy twice, but could not put the ball into the net.

Humphry had hard lines in not scoring for us, as the ball hit the crossbar, and bounced about in the mouth of the goal; but alas! there was nobody there to put it through. Three corners in succession now fell to Guy's, and were beautifully placed by Swan, but the "Fates" were against us, and Fox brought off some really marvellous saves. A few minutes before the interval was called, Fitz-Hugh received a clever pass from Alexander, and had the goal at his mercy, but evidently mistaking the corner flag for one of the uprights, made a good attempt to hit it. Half time was called with no score.

Starting after the interval, it was generally thought that Bart's having the wind at their backs, would win pretty easily, but thanks to erratic shooting, and the brilliant defence of Carter and Davis, they were unable to score in the first 30 minutes. At the other end Guy's had some narrow shaves, nearly scoring on several occasions. Ill-luck which had forgotten us during the first 30 minutes of the second half, made up for this neglect, and dealt its *coup-de-grace*; for Carter, who was practically the best man on the field, was hurt and rendered useless for the rest of the game.

Immediately after this misfortune, Bart's broke through our crippled defence, and scored the only goal of the match.

From this till call of time, Guy's, though practically playing ten men, had slightly the best of it, but were unable to score; and whatever defensive work was required, was magnificently done by Davis. On time being called, Bart's were left winners of the Cup by the narrow margin of one goal to nil.

Fox, Wittaker, and Hay, for Bart's; Lavers, Davis, Carter, and Walker, for Guy's; were the pick of the two teams.

Our forwards were clean off colour, and as for the shooting, it was simply disgraceful; of course we must make allowance for the high wind that was blowing, which did away with accurate play. To add to all this, Palmer was a passenger in the team, never attempting to do any work all through the match. The half-backs played a fine defensive game, but in the attack were apt to kick too hard.

Too much praise cannot be bestowed on the two backs for their wonderful defence, and it is a matter of great doubt whether Bart's would have scored if Carter had not been disabled.

As for Lavers, he could not do wrong, and, in fact, the shot that scored would have beaten the best goal-keeper in England. Team:—

Guy's—N. Lavers (goal); W. R. Davis, A. B. Carter (backs); R. H. J. Swan, F. E. Walker, A. E. Crosby (half-backs); K. B. Alexander, W. G. Palmer, R. T. Fitz-Hugh, R. B. Stamford, L. Humphry (forwards.)

H. B. O.

GUY'S v. WEST CROYDON.

At Croydon on 16th March, we met the above team who are the finalists for the Surrey Cup, but they were no match for us, having to acknowledge defeat by no fewer than 6 goals to 1. Our goals were scored by Humphry, Fitz-Hugh (2), Waymark (2), and Stamford.

GUY'S v. MIDDLESEX.

Played at Leyton on March 19th, and resulting in a win for Guy's by 4 goals to 2, after a scrambling and uninteresting game.

In the first portion Middlesex were the first to score, but at the interval honours were easy.

In the second half our opponents again took the lead, but afterwards fell away and allowed Guy's to score three times and so enter the final.

Our goals were scored by Humphry, Fitz-Hugh, and Walker (2), in the order named.

The pick of the team were Carter, Walker, Fitz-Hugh, and Palmer. Team :—

Guy's.—N. Lavers (goal); W. R. Davis, A. R. Smith (backs); R. H. J. Swan, F. E. Walker, A. E. Crosby (half-backs); P. S. Mandy, W. G. Palmer, R. T. Fitz-Hugh, R. B. Stamford, L. Humphry (forwards).

Rugby Football.

RUGBY FOOTBALL CLUB, 1894–5.

Played 16; won 7; lost 8; drawn 1; scored 4 goals 11 tries (52 points) to 11 goals 10 tries (82 points).

Bell scored 5 tries; Rae, 4 tries; Morgan, 2 tries; Wetherell, Mathias and Hancock, 1 each. Goals by Hancock, 3; Dudgeon, 1. Thirty-one men have been tried in the First XV.—15 backs and 16 forwards.

H. W. Dudgeon 16 matches (3rd season without having missed a match).

	Matches.		Matches.
K. B. Alexander	15	R. J. Rowlands	12
F. C. Wetherell	15	C. R. Nicholson	11
W. Tyson	13	E. G. Goddard	10
L. F. Rae	13	R. S. Rowlands	9
P. D. Hunter	13	A. S. Ransford	9
H. T. Bell	12	C. A. Trouncer	8
P. A. Dykes	12	J. N. Gardiner	8

The others less than half the matches.

We have been rather unlucky in having good men, especially the outsides, rather too frequently absent, but this was, to a great extent, owing to injuries and illnesses.

We have beaten Rosslyn Park, Wickham Park, Catford Bridge, Lennox, Kensington, and East Sheen (twice). Our drawn game was with Old Merchant Taylors, always a near thing with these old opponents.

Our defeats have been at the hands of Cambridge, Leicester, Leeds, Coventry, Bristol, Northampton, Old Leysians and St. Thomas's. Five out of the eight will be seen to be out matches, in fact we lost *all* our out matches without exception. In our last defeat, at the hands of St. Thomas's for the cup, the team played quite up to its reputation, but St. Thomas's went one better and won, that is all that can be said. The men in the team this season to receive their "blues," who have not already got them, are F. L. Rae, T. L. Jackson, C. A. Trouncer, R. S. Rowlands, P. A. Dykes, E. G. Goddard and P. D. Hunter.

At a meeting of the team a few days ago the two following were awarded honour caps:—H. W. Dudgeon and H. T. Bell. There will be three of the present team at least out of their year next season, and it is probable that one or two more may be gone by then. For next season the fixture list is rather stronger than this year, but there are fewer out matches, Northampton and Bristol having been dropped. The new clubs taken on are London Scottish, Harlequins, and one extra match with Old Merchant Taylors. So to have a successful season we will want a few good new men, plenty of keenness and *esprit de corps*.

The spring meeting to elect officers, etc., for the coming season, will be held some time in May next.

H. W. DUDGEON, Hon. Sec.

GUY'S 2nd XV., 1894–5.

The weather has interfered very considerably with our fixtures, but, although seven had to be scratched on that account, yet the season has been fairly successful. Out of 12 matches played, 6 have been won, 4 lost, and 2 drawn, and we have scored 105 points against 61. Of the defeats, two were at the hands of Sidcup, one by Brockley, and the other by a Streatham team. We have not, therefore, been beaten by any second team. In the first match with Sidcup we were only beaten by two tries to one, after an extremely even game, and in the return the influenza had made such havoc among our footer men that we only played 14 men, and 4 of our outsides were forwards; so it was no disgrace to be beaten by 20 points.

Of the victories, the greatest score we ran up was against Lennox 2nd, 7 goals and 2 tries, while perhaps the most creditable achievement was twice beating the London and Westminster Bank, who were otherwise unbeaten.

For the first time gate-money has been taken at Honor Oak Park for second matches, and we have managed to attract sufficient spectators to pay the man for collecting the gate. With the exception of a most enjoyable trip to Folkestone, all our matches have been played around London, and the result of our travels has clearly convinced us of the fact that there is no place like Honor Oak Park for football.

There has been no lack of forwards, but outsides, especially centre three-quarters have been badly wanted. The forward play all through has been considerably above the average, and several ought to stand a very good chance of their "blue" next year. As usual, most of the

men who have scratched for the second have done so on account of men in the first failing, and it is this that makes the strength of our team so variable, most of our defeats being no fault of our own; and, indeed, if it had not been for the sportsmanlike way in which men out of their year have come to our rescue, this somewhat inexplicable fact might have caused a larger list of defeats.

In conclusion, men who are in the habit of playing football would greatly aid the captain of the 2nd XV. and help also to maintain the efficiency of the team by a closer attention to the team lists in the Colonnade.

A. J. C.

GUY'S 2nd XV.

Detailed List of Matches.

Date.	Opponents.	Rslt.	For Gls.	For Trs.	For Pts.	Against Gls.	Against Trs	Against Pts.
1894								
Oct. 13.	–Brockley ...	L.	0	0	0	3	0	15
20.	–Streatham A.	L.	0	0	0	1	4	17
27.	–Kensington A.	W.	2	4	22	0	0	0
Nov. 1.	–L. & W. Bank	W.	0	1	3	0	0	0
10.	–Currie's School	W.	2	5	25	0	0	0
17.	–Lennox A. ...	W.	7	2	41	0	0	0
24.	–Middlesex Wanderers	Dn.	0	0	0	0	0	0
Dec. 8.	–Sidcup A. ...	L.	0	1	3	0	2	6
1895								
Jan. 19.	–L. & W. Bank	W.	1	0	5	0	0	0
Feb. 23.	–Brockley ...	Dn.	0	0	0	0	0	0
Mar. 2.	–Sidcup A. ...	L.	0	0	0	3	2	20
16.	–Old Merchant Taylors A.	W.	0	2	6	1	0	4

Matches won 6, lost 4, drawn 2. Score for 12 goals, 15 tries, 105 points; against 8 gaols, 8 tries, 61 points.

United Hospitals' Cycling Association.

The Annual General Meeting of the above Association was held at Guy's on March 21st.

Mr. Noble, who was in the chair, read letters from Mr. Golding-Bird and Mr. Openshaw, expressing their regret at being unable to attend.

The Secretary then read the annual report. Mr. Hopkins, in moving that the report should be adopted, said that the Association was on a firm basis, and that its success during its first year was worthy of congratulation. This motion was seconded by Mr. Bruzaud, and carried *nem. con.*

The balance sheet was then read, and some alterations were made in the rules, the chief one being that the annual subscription from the larger Medical Schools be £3 3s., and from the smaller ones £2 2s.

The runs for the year were then settled, the first being to Brighton on May 18th, returning on the 20th. It was arranged that the Inter-hospital races for the Challenge Shield be held during the last week of June, the track being probably Herne Hill or Catford.

The officers for 1895 were then elected:—President: J. H. Openshaw, Esq., M.S. Captain: H. Milbank-Smith, Guy's. Vice-Captain: A. F. Millar, St. Thomas's. Hon. Secretary and Treasurer: A. S. Bruzaud, London.

Mr. Noble then proposed a vote of thanks to our Ex-President, Mr. Golding-Bird, which was most heartily responded to.

There were twenty-two members present, the following hospitals being represented: Guy's, London, St. Thomas's, St. Mary's and University College.

The meeting adjourned with a vote of thanks to the Chairman.

Guy's Hospital Lawn Tennis Club.

A General Meeting of the above Club was held on Wednesday, March 27th. Mr. Lane, president, kindly took the chair, there being SIX members present.

The following officers were elected:—Captain: A. V. Clarke. Vice-Captain: A. B. Carter. Committee: H. W. Dudgeon, W. I. Hancock, E. D. Hancock, H. A. Higgins, W. H. Peake. Honorary Secretary and Treasurer: A. B. Carter.

Guy's Hospital "Blue."

At a meeting of the "Blues" Committee held on March 29th, the following Past and Present Students were awarded their "Blue":—

FOOTBALL.

Association.—Past.

Roberts, C. Gordon.

Rugby.—Past.

Blaker, L. C.

ATHLETICS.—Past.

Desprez, H. S.

CRICKET (Season, 1894).—Present.

Alexander, K. B. Pike, N. H.
Perks, A. Prince, P. C.

TENNIS (Season, 1894).

Carter, A. B.

FOOTBALL (Season, 1894–5).

Association.

Barker, M. S. Davies, W. R.
Crew, E. J. Humphry, L.
Mandy, P. S.

Rugby.

Dykes, P. Jackson, T. L.
Goddard, E. G. Rae, R. L.
Hunter, C. D. Rowlands, R. P.
Trouncer, C. A.

H. HEWETSON,
Hon. Sec. "Blues" Committee.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling *and* Sixpence.

Guy's Hospital Gazette.

APRIL 27, 1895.

On Recto-Vesical Hydatid Cysts.

By J. H. TARGETT, M.S., F.R.C.S.

The report of a case of this disease was lately read before the Medico-Chirurgical Society, and the question of its morbid anatomy was raised. As the views expressed by me were not in accordance with the statements made in text-books, I will briefly explain them.

Morbid anatomy.—The disease consists in the formation of a hydatid cyst in the cavity of the true pelvis between the bladder and rectum in the male. Cysts somewhat similarly placed are found in the female, but we will confine our attention to the male.

The point at issue is, in the first place, one of ordinary anatomy. Where are these cysts situated? Are they in the recto-vesical pouch of peritoneum, that is, intra-peritoneal; or are they in the cellular tissues, outside the peritoneum? More than a hundred years ago, John Hunter recorded a case of this kind, and he assumed that the hydatid embryo had dropped down into the pelvic pouch of peritoneum from a source in the upper part of the abdominal cavity, and had gradually enlarged there until it filled the pouch, and displaced the bladder forwards and upwards. Fortunately for my purpose, that specimen was preserved, and may be seen in the College of Surgeons' Museum. I shall refer to it again. Dr. Fagge, in his "Medicine," adopts the same view. He says: "There is a very remarkable variety of hydatid tumour, which developes itself in the pelvis between the bladder and the rectum. In these cases, the six-hooked embryo doubtless got into the serous cavity when it had penetrated the walls of the stomach, and fell by its own weight into the most depending part of the peritoneal sac." From both these quotations it is clear that the authors regarded the pelvic hydatid cysts as intra-peritoneal; but an examination of the specimens preserved in the various museums in London, shows that this is not the case, or at least, not in the great majority of instances. When the parts are dissected, the cyst is found in such a relation to the bladder that there can be no doubt of its extra-peritoneal origin. I have come to the conclusion that the hydatid is developed between the muscular coat of the bladder and the recto-vesical fascia which ensheathes it. The following reasons for this conclusion may be given:—

1. The hydatid cyst is situated at the back of the bladder, and in each specimen it is easy to demonstrate the fact that the vas deferens and vesicula seminalis of one or both sides is lying upon the wall of the cyst and not upon the bladder. Now, it will be remembered that the vesical portion of the recto-vesical fascia forms a distinct covering to the lower part of the bladder, and at the same time envelopes the vesicula seminalis and ends of the vasa deferentia. To detach these structures from

the vesical wall, the distending force must be applied between the muscular coat and the fascia, for if the cyst were external to the fascia in the subperitoneal fat the vasa and vesiculæ would never lie upon its wall, but, on the contrary, would be compressed against the bladder.

2. A simple experiment proves that the recto-vesical fascia can be readily detached from the bladder, and at the same time the vesiculæ are displaced. The male pelvic viscera are removed from the body *en masse*, and the bladder is opened in front. With a sharp knife the mucous and muscular coats at the base of the bladder are carefully divided; then, laying aside the knife, the soft tissues external to the muscular coat are pushed back with the forefinger. A cavity is thus easily made, which may be stuffed out with wool, and the preparation hardened in spirit. On subsequent dissection it is found that there is an artificial cyst or space at the back of the bladder between the muscular coat and the recto-vesical fascia, and that the vesiculæ and vasa do not rest on the bladder but cross the sides or back of the artificial cyst.

3. The counterpart of this experiment is occasionally met with as a natural process. When sacculi of the mucous membrane and other cystic tumours of the vesical wall project far backwards from the base of the bladder they produce a precisely similar displacement of the recto-vesical fascia and of the vesiculæ seminales and vasa deferentia.

Granted that the hydatid cyst is formed in the site indicated, how does the six-hooked embryo reach that spot? Certainly not in the manner described by Dr. Fagge, for that would imply penetration of three distinct layers, viz., peritoneum, subperitoneal fat, and recto-vesical fascia. Probably the embryo is deposited from the large venous plexus about the base of the bladder beneath the fascia, just as hydatids occur in the epiphysial ends of the long bones, and in the bodies of the vertebræ where the vessels are most abundant. It has been suggested that a hydatid of the kidney might make its way into the bladder, and then perforate the wall to reach the subfascial space; but there is no evidence in favour of this view.

Hence, a recto-vesical hydatid cyst must be looked upon as a primary disease, which may be associated with hydatids in the liver or other organs, but cannot be secondary to them by direct infection. In like manner the hydatid disease of bone is primary, for in only 5 out of the 75 cases on record have cysts been found in other parts than the skeleton.

The later effects of the pelvic hydatid are not difficult to understand. By its gradual enlargement the rectum and bladder are compressed, the pelvic pouch of peritoneum is obliterated, and a large abdominal tumour is formed. Two very typical specimens of this disease have been recently added to the College Museum, and are thus described:—

3747 B. A urinary bladder and the lower end of the rectum, between which is situated a hydatid cyst the size of a fœtal head. Its upper surface is covered with peritoneum which has been stripped from the back of the bladder, and posteriorly a narrow serous pouch is seen which corresponds in position with the recto-vesical pouch of the peritoneum. The vesiculæ seminales and vasa deferentia have been separated from the wall of the bladder by the gradual enlargement of the cyst, to which they are attached on its lateral and inferior surfaces.

From a man, aged 25, who during the last six months of his life had suffered from headache, occasional vomiting, and progressive emaciation. A few days before his death there was suppression of the urine, and a large tense tumour was discovered occupying the cavity of the pelvis. At the autopsy it was found that the ureters were compressed by the hydatid cyst as they passed over the brim of the pelvis, and that the pelves and calyces of the kidneys were enormously dilated.

3747 C. A urinary bladder and the lower end of the large intestine, showing a thick-walled hydatid cyst in the recto-vesical space. It measures eight inches in its longest diameter, and is somewhat constricted in the centre. As in the preceding specimen, the vesiculæ seminales and vasa deferentia have been stripped from the bladder and are in contact with the wall of the cyst. In the recent state the cyst

was filled with shrivelled hydatid membranes. The bladder and rectum are healthy.

From a man, aged 50, who came under observation for a swelling in the lower part of the abdomen, which he had first noticed six months previously. It gradually increased in size, and caused much suffering by compression of the bladder and rectum, but the patient refused to submit to any operation for his relief. At the autopsy it was found that the liver contained hydatid cysts, one of which projected from its anterior border near the gall-bladder.

The Hunterian specimen mentioned above is particularly interesting, for in spite of John Hunter's opinion, and the fact that there were several large hydatid cysts between the stomach and the spleen, from which an embryo might have gravitated into the pelvic cavity, yet, when the relations of the cyst were investigated, the characteristic displacement of the vesicula and vas on one side was revealed.

Symptoms.—Beside compression of the bladder and rectum, it is important to remember that a pelvic hydatid may obstruct the ureters and cause double hydronephrosis, or press upon the iliac veins and sacral plexus, producing œdema, sciatica, and even loss of power in the leg. The effect on the bladder is two-fold. Sometimes this viscus is merely compressed and displaced to one side, but the passage of urine is not obstructed. At other times there is pressure on the neck of the bladder and retention of urine, as in Hunter's case, where the bladder reached eight inches above the pubes, and contained five or six pints of urine.

As regards *treatment*, two modes of operating have been advocated, the one through the perineum, the other by abdominal section. Owing to the tendency of these cysts to burrow downwards and thus come into relation with the prostate, it follows that they will be easily reached in some instances through the perineum, but the space available for thoroughly excavating the contents is insufficient, and prolonged drainage may be required. On the other hand, abdominal section provides free access, and enables the cyst to be dealt with after the method introduced by Mr. Bond, of Leicester, that is, careful removal of the entire contents of the cyst, and immediate closure of the incision in the cyst wall without drainage of any kind. The abdominal operation may be complicated by the presence of a greatly distended bladder, and in two or three cases this viscus has been laid open in mistake for a hydatid cyst, which in reality was situated behind it in the abdominal cavity.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	13.	Aortic aneurysm. Aortic regurgitation.
	15.	Anæmia.
	19.	Ulcerative endocarditis.
	42.	Mitral disease.
	43.	Chlorosis.
	50.	Mitral regurgitation.
Philip	4.	Pernicious anæmia.
Stephen	20.	Aortic disease.
	28.	Mitral regurgitation.

Nervous System.

Mary	1, 6.	Post-influenzal debility.
	4.	Peripheral neuritis.
	9.	Cerebral tumour. Optic atrophy.
	29.	Hysteria.
	31.	Right hemiplegia and aphasia.
	45, 46.	Chorea.
Stephen	2.	Multiple neuritis. ? Syphilitic.
	5.	Ataxic paraplegia.
	12.	Cerebral tumour. Optic atrophy.
	30.	Locomotor ataxy. Laryngeal paralysis.
	32.	Exophtha'mic goitre. Glycosuria.
	34, 39.	Cerebral tumour. Trephining.
	38.	Myelitis.

Alimentary System and Abdomen.

Mary	8.	Hydatid of liver.
	18.	Abdominal tumour. ? Hydatid of liver.
	22.	Ascites. Enlarged spleen. ? Cirrhosis of liver.
	48.	Gastritis.
	49.	Abdominal pain. ? Cause.
Philip	3.	Hepatic abscess.
	7.	Gastric ulcer.
	16.	Tuberculous peritonitis.
	36.	Typhoid fever.
Stephen	9, 11.	Tuberculous peritonitis.
	10.	Chronic diarrhœa.

Genito-Urinary System.

Mary	30.	Moveable kidney. Cystic thyroid.
Philip	18.	Acute tubal nephritis.
Stephen	6.	Chronic tubal nephritis. Optic neuritis. Albuminuric retinitis.
	16.	Diabetes mellitus (boy, æt. 4).
	19, 25.	Diabetes mellitus.

Respiratory System.

Mary	16, 41, 32.	Phthisis.
	27.	Broncho-pneumonia.

Mary	37.	Pleurisy. Pregnancy.
Philip	9, 12.	Phthisis.
	26.	Fibroid lung. Bronchiectasis.
	28.	Pleurisy.
Stephen	1, 7.	Pleuritic effusion.
	13.	Broncho-pneumonia.
	17.	Phthisis.

Miscellaneous.

Mary	3.	Gout.
	11.	Eczema.
	17.	Tonsillitis.
	28.	Pleuritic effusion. Œdema of legs. Hæmaturia. Pericarditis. History of having hydatids in urine.
	34.	Acute rheumatism.
Philip	1.	Spinal caries.
	6.	Acute rheumatism.
	23.	Otitis media, getting pneumonic.
	31.	Gout.
	34.	Gonorrhœal rheumatism.
	40.	Vesical calculus.
Stephen	3.	Acute rheumatism.
	8.	Tuberculous arthritis.

Case under Dr. Goodhart.

Mary.

18. J. W., æt. 40, transferred from Dorcas, April 10th, 1895, for large swelling on right side and front of abdomen. Patient is single, and her occupation that of a parlour-maid. Her work has never been of a very arduous character, and she is a moderate drinker. Menses started when she was 13, and have always been regular. She has never had any children, and she does not tight lace.

Family history.—Father died at 60, from consumption and paralysis. He was a moderate drinker. Mother died when patient was nine years of age. Four brothers and one sister, all healthy.

Previous medical history.—Twenty years ago patient suffered from inflammation of the liver and jaundice, but got better after a month's illness. She has also suffered a good deal from constipation, but otherwise has always had good health.

History of present illness.—Ten weeks ago patient began to suffer from pain in the abdomen, the pain only being present when standing or wearing tight clothes. She was treated by a medical man for indigestion and congestion of the liver. While under treatment she noticed that her abdomen began to swell on the right side, and her doctor advised her to see Dr. Galabin, who admitted her into Dorcas, March 27.

On examination, the fundus and cervix seemed pushed over to left side. Uterus appears to be anteflexed. Patient has not lost flesh or strength. When admitted into Mary she looked perfectly healthy, with a flushed face due to stellate venules. There is a large globular swelling occupying the whole of the right hypochondriac and lumbar, and half the umbilical and inguinal regions. The swelling moves with inspiration. Tense, elastic and fluctuating. No thrill to be felt. The skin is not altered over swelling. Dull on percussion; dulness continuous with liver dulness. This is a case for diagnosis. The following has been suggested:—Distended gall-bladder; hydatid of the liver; ovarian cyst with a long pedicle; and tight lacing, causing a descent of the liver. The latter, however, does not seem probable, as the appearance of the woman goes against it.

Dr. Goodhart added the following to the report:—The tumour is certainly peculiar. When not under an anæsthetic there is a large globular mass, like the report describes, extending well over to the left side beyond the median line above the umbilicus, as well as occupying the posterior part of side and to left of umbilicus. I could hardly say that there is fluctuation or a thrill to be felt, the muscles being so rigid that it is difficult to get quite at the tumour. When under an anæsthetic, the muscle is long before it quite relaxes; when it does, the hardness of the apparent cyst all gives—its dimensions also contract, and it appears to be much more like a simple big globular right lobe of liver.

Case under Dr. Perry.

Miriam.

17. Florence W., æt. 19. Admitted for rythmical, oscillatory movements of head.

Family history.—Mother has had rheumatic fever twice, and has been in Guy's for heart disease. There is no history of neurosis.

Previous history.—Two and a half years ago patient attended Dr. Washbourn's out-patients for similar movements of the head. She says it was called St. Vitus's Dance. The affection then lasted for six months, remaining confined to the head. There have been no movements since till the onset of the present attacks. Patient has had no other illness; no rheumatic pains; and has had no hysterical manifestations, as fits, globus, etc.

Catamenis.—Menstruation has been regular except during the previous attack, when there was amenorrhœa for six months.

Present illness began one month ago. Patient was at her work as clerk in an indiarubber works, when her head began to move as on admission. This was about one week after the termination of the last menstrual period. Patient does not know of any fright, worry or overwork to which the illness might be attributed. She has been at home for the last three weeks, the movement getting worse. A doctor who was called in diagnosed St. Vitus's Dance. Patient came up to Dr. Washbourn's out-patients, on Wednesday, April 10th, and was admitted into Clinical.

On admission.—Temperature, 96·4; pulse, 110; respiration, 18. Patient is a well-nourished but anæmic girl. She has continuous oscillatory movements of the head,

varying from 60 to 120 per minute. The movements are regular and rythmical, their rapidity depends on whether patient is being watched or excited in any way. They are lateral in direction, there being very slight up and down movement of the chin.

The sterno-mastoids can be seen to contract alternately. The head is motionless during sleep. The eyelids close rhythmically and rapidly, but no other facial muscles are affected. The tongue is not tremulous. There is no tremor of any other part of the body and no loss or power.

Sensation is normal. There is no hyperæsthesia.

Reflexes.—Plantar reflexes and knee-jerks very lively. No ankle or patella clonus.

Trophic changes: none. No trouble with micturition or defæcation.

Speech is not affected. It has no scanning or syllabic character.

Eyes.—Pupils normal. No fundus changes. No nystagmus or oculo-motor paralyses.

Circulatory system.—Apex beat in fifth space; one inch internal to nipple. Cardiac dulness normal. First sound of heart at apex is not clear, and is thought by some to be followed by a bruit.

Alimentary and *respiratory* systems normal.

Diagnosis of hysteria made.

Treatment.—Rest in bed; full diet.

Pot. Brom. gr.x.
Tinct. Asafœt. ɱxv.
Syr. Aurantii ʒi.
Inf. Valerianæ ad ʒi. t.d.s.

Pil. Nucis Vomicæ et Ferri gr.x. o.n.

Progress.—Patient made rapid improvement. She was of opinion that the movements were much less marked after each dose of the medicine.

April 19th.—Patient was taken to the electrical department for treatment. A fairly strong Faradic current was applied over the sterno-mastoids for about 15 minutes.

20th. This morning the Faradic current was again applied, and the movements ceased.

Patient went out next day the movements not having returned.

The diagnosis lay between hysteria, chorea, and disseminated sclerosis.

Against disseminated sclerosis, were the absence of the two other classical symptoms, nystagmus and scanning speech; the fact that the movements were not "intention tremors" and the movements themselves were too rhythmical.

In favour of chorea were, the rheumatic history in the mother, the fact that the previous attacks were thought to be chorea, the doubtful presence of a systolic bruit at the apex.

Against chorea, the limitation of the movements to the head and neck, and their rhythmical character. The fact of their yielding to anti-hysterical remedies and the Faradic current, was strongly in favour of the diagnosis of functional disease.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman
4. Epithelioma penis; amputation.
5. Ununited fracture of arm.
7. Irreducible femoral omental hernia; operation for radical cure; omentum apparently undergone sarcomatous change.
9. Infective periostitis of fibula: incision.

Charity
Fractured patella.
11. Fractured neck of femur.
12. Pulpy knee; excision.
14. Fluctuating swelling in gluteal region; ? breaking down gumma.
14. Cleft in soft palate.
16. Induration of breast; removal of indurated nodule.
20. Chronic condensing osteitis of tibia; necrosis; amputation of leg.
Cot. Scalded throat; tracheotomy.

Cases under Mr. Davies-Colley.

Cornelius
3. Wound into metacarpo-phalangeal joint of great toe.
4. Displaced internal semilunar cartilage of knee-joint. Patient came up with knee locked in flexed position; an anæsthetic had to be given before reduction could be effected.
5. Fractured pelvis. Fracture running through ilium; no injury to viscera; inability to stand on leg or raise weight of leg from the bed.
6. Fractured ribs and emphysema.
9. Scalp wound and depressed fracture over back of skull.
12. Laceration of soft palate.
20. Lower jaw fractured a little to the right of the symphysis. Splint fitted by Mr. Pedley.

Lydia
8. Inguinal hernia.
8. Carcinoma recti. Excision of growth by lateral incision through ischio-rectal fossa, leaving anus intact.
17. Molluscum fibrosum attached to vulva.
21. Femoral hernia.
22. Ankylosis of hip. Tuberculous hip disease. Excision.
Cot. Suppurative synovitis of knee-joint following a fall.

Luke
2, 18. Strangulated inguinal hernia.
4. Talipes equinus; paralysis of tibialis anticus; operation.
5. Effusion into knee-joint; thickened fringes; ? tubercular.

Luke	8.	Tubercular disease about astragalo-scaphoid joint; excision of head of astragalus.
	9.	Enlarged prostate; double castration.
	12, 17.	Stricture. Retention.
	13.	Epitheliomatous ulcer of thigh, originating in scar of burn.
	14.	Carcinoma recti.
	15.	Chronic abscess, head of tibia; abscess opened.
	20.	Syphilitic periostitis of tibia (congenital).

Cases under Mr. Lucas.

Job	9.	Stricture of urethra. Retention.
	19.	Impermeable stricture. Old Cock's operation. All urine passed through perineum. Closure of perineal opening, with retention of urine.
	22.	Strangulated femoral hernia. Kelotomy.
	25.	Reducible inguinal hernia.
Lydia	10.	Lipoma on shoulder.
	13.	Pain in loin and abdomen, paroxysmal. ? Renal.
	16.	Fractured femur.
Accident	20.	Cut across front of ankle-joint. ? Wound of joint.
	25.	Fractured femur.

Cases under Mr. Golding-Bird.

Martha	4.	Double moveable kidneys. Previous nephrorrhaphy.
	4.	Fractured patella. Fragments wired.
	7.	Proliferating cyst. Adenoma of ovary. Removal. (Clinical P.R.)
	8.	Abscess in thigh. Sinus in loin. ? Spinal in origin.
	17.	Nævus in neck.
	Cot.	Ununited fracture of leg in child of 15 months old.
Lazarus	6.	Tubercular abscess in neck.
	6.	Cystic swelling in median line of neck. Removal. Dermoid.
	8.	Ingrowing toe-nail.
	12.	Carcinoma recti. Inguinal colotomy.
	14.	Sciatica. Sciatic nerve sketched.
	15.	Lupus verrucosus over knee.
	16.	Bronchocele. Rounded mass in left lobe at root of neck. Difficulty in breathing when lying down.

Cases under Mr. Symonds.

Martha	13.	Enlarged kidney removed. Surgical kidney. No obvious source of infection.
	Cot.	Hare-lip. Cheiloplasty.
Luke	16.	Perineal section for abscess in prostate; with prostatic calculi.

Case under Mr. Lane.

Job	15.	Displaced internal semilunar cartilage of knee; cartilage removed; found to be partially worn through.

Case under Mr. Lucas.

A Case of Cock's Operation performed 14 Years ago.

Patient, J. K., æt. 63, suffered from an attack of gonorrhœa as far back as 1855. In 1879 he first experienced great difficulty in passing water. From this date up to 1882, the stricture became more and more impermeable, and in the latter year he was admitted into Guy's Hospital, under the care of Mr. Lucas, for impermeable stricture.

Mr. Lucas then performed Cock's operation, and tied a No. 12 catheter into the passage made in the perineum. At the same time an attempt was made to penetrate into the uretha through the penis. A No. 3 silver catheter was passed in, but was of no effect. Patient never passed his water through the penis again. The wound in the perineum healed up well, and patient went out able to pass a No. 12 catheter through the passage in the perineum.

In July, 1889, patient again came up to the Hospital on account of the contracting up of the orifice of the passage. Mr. Lucas enlarged this.

Patient came up again this year on April 18th. He could now only pass a No. 4 catheter into the passage, which was gradually contracting up again. Mr. Lucas has enlarged the orifice by skin incisions, and found it also necessary to open up the passage a little more by deeper incisions.

At the present date (April 25th) the patient is progressing very satisfactorily, and is passing his water through a No. 12 catheter which is tied into the passage.

Guy's Hospital Dental Department.

Practice during March, 1895.

Gold Fillings	...	368
Amalgam ,,	...	518
Osteo ,,	...	
Perm. G.P.,,	...	
Regulations	...	9
Artificial Crowns	...	49
Dentures	...	10
Dead Teeth	...	146
Scalings	...	41
Attendance for Extraction under Anæsthetics	...	1118
,, ,, without ,,	...	614
Total	...	2873

An unusual number of Specimens of Ascaris Lumbricoides from one patient.

A boy, 11 years of age, who died of appendicitis with suppurative peritonitis, passed a few days before death eight round worms and vomited another; in his intestines at the autopsy were found 24 more specimens, making in all a total of 33; so far as could be ascertained the worms had nothing to do with the causation of the appendicitis.

Of 16 specimens which I was able to examine, 9 were females, 7 males; the females varied from 4 to 10¼ inches in length, and averaged 7½ inches; the males varied from 5¼ inches to 5¾ inches, and averaged 5½; they were all situated in the small intestine. The case is rather uncommon, firstly, in the presence in one individual of 33 round worms, the number as a rule being much smaller; secondly, in the large proportion of males, most authorities stating that they are seldom met with. According to Cobbold, as a rule only a single specimen, or at most from three to eight of these intestinal parasites are found in the same individual at one time, but every now and then it is found that considerable numbers are present. Küchenmeister alludes to a case in which 103 were passed by one child, and to another whose alimentary canal contained between 300 and 400. Gillin (*Turin Journal of the Medical Sciences*) records an instance in which no less than 500 came from one child, and Cruveilhier removed 1,000 from the intestines of an idiot. It is quite rare to get these large numbers in adults, most of the recorded examples being in children. The common position, as in this case, is in the small intestine, but they may be found in the stomach and other parts. The average size of adult worms, as given by Fagge, is 15 inches for the female, 10 for the male. The above mentioned ascarides were a good deal smaller than this.

L. A. PARRY.

A Case of Renal Calculus,

WITH A REMARKABLE ABSENCE OF SUBJECTIVE SYMPTOMS, SHOWING THE VALUE OF PERCUSSION AS A MEANS OF DIAGNOSIS.

The case appended is one of great interest. It is published by kind permission of Dr. Knight and Mr. Brook. A robust, muscular young collier, aged 22, was sent into Swansea Hospital, on the medical side, last September, as a case showing signs of appendicular mischief.

The history was that for three years he had complained of dull aching pain on the right side of the abdomen, which was getting worse. This pain was almost constant, but was sometimes much worse—so severe that he had to give up his work and take to his bed. The attacks bore no very definite relation to exercise, and came on at irregular intervals. They were accompanied by colic and nausea and lasted from 12 to 36 hours.

There seemed to be some relation between these attacks and constipation, an attack of constipation often being followed by a severe attack of pain. This relation between the pain and gastro-intestinal symptoms led to his adopting milk diet for five weeks, on the advice of a medical man. He was quite unable to earn his living.

On examination, there was a tender area to the right and below the umbilicus, the point of greatest tenderness being midway between the anterior superior spine and the middle line, *i.e.*, immediately below McBarney's point. There was nothing to be felt by deep palpation in the iliac or lumbar regions.

Deep pressure caused slight pain, but it was doubtful whether more than on the left side.

The urine was repeatedly examined and always showed a trace (but never more) of albumin.

No blood or crystals were ever found, although repeated microscopic examinations were made. On being pressed carefully he gave a vague account of having once passed some dark urine some months before.

He never complained of pain in testicle or any part of the penis, neither did he ever complain of pains shooting down the thigh.

At the patient's urgent request it was decided to examine the vermiform appendix, and if necessary to continue the incision backwards so as to examine the right kidney.

Mr. Jacobson, in his "Operations of Surgery" quotes Mr. Jordan Lloyd as follows:—"I attach great importance to the evidence to be obtained by immediate percussion over the suspected organ, a method of investigation which has not received that amount of attention to which it is entitled. It is best practised from the loin, just beneath the space between the tips of the last two ribs, and should be made in a direction upwards, forwards, and slightly inwards. It is best for the patient to stand upright before you. The blow should be sharp and decisive, and of a force sufficient to effect a structure situated several inches below the surface. It may also be practised from the front, at a point midway between the umbilicus and the ninth rib. When a calculus is present, the patient will complain of sharp stabbing pain at the moment of percussion. Other conditions doubtless give rise to percussion pain, but not to the characteristic stabbing pain of calculus."

Percussion was tried on the patient, and elicited severe pain; as if something sharp were being stuck into him.

Lumbar nephrotomy was performed next day. A stone was discovered by needling, although none could be made out by palpation with the finger. It was lying loose in the pelvis, which was somewhat dilated, and was removed through an incision in the kidney substance.

Very free hæmorrhage followed, which was controlled by plugging with strips of gauze both the wound in the kidney and the spaces in front and behind the organ, with a view of obtaining further pressure. Great

difficulty was found in keeping the kidney in the wound as it slipped up under the ribs.

The stone weighed 83 grains, and consisted entirely of oxalate of lime. It was covered with sharp needle-like crystals heaped one on another in an irregular way.

It is very difficult to understand how such a stone could be in the pelvis of the kidney, without causing more subjective symptoms.

The psoas and quadratus behind, and the abdominal muscles, might have held the stone in position very firmly, and prevented it slipping about.

I quote the classical symptoms of renal calculus from Jacobson :—

(i.) "Continued hæmaturia, or passage of blood and pus "—absent.

(ii.) "Pain and tenderness, lumbar and elsewhere." In this case the pains were very vague. Radiating pains were absent. Tenderness *on percussion* well marked.

(iii.) "Points in previous history" favoured the idea of appendicular rather than renal mischief.

(iv.) "Frequency of micturition "—absent.

(v.) "Absence of any condition in the rest of the genito-urinary tract, which will explain the symptoms." —(Morris.) Nothing in this case.

(vi.) "Failure of previous treatment to give relief "—as in this case.

It only remains to add that the patient made a good recovery.

A Viva-Voce Examination in Surgery for the Diploma of M.R.C.S. Eng.

First Day.

Examination Hall, Thames Embankment.

Clinicals, 5 p.m.

Case I.—A middle-aged man, who had been a soldier, presenting enlarged glands about anterior border of left sterno-mastoid muscle below angle of jaw. Two months' history. Painful; deeply fixed; skin attached. Interior of mouth and pharynx examined for primary source. Patient gave history of increasing difficulty and pain on swallowing food in upper part of œsophagus; spitting of blood. Case one of epithelioma of œsophagus secondarily involving glands of neck. Candidate was asked what treatment he would adopt.

Case II.—Elderly man presenting round ulcer on back of right hand, with raised edges, rolled over, following injury. Enlarged gland over internal condyle of humerus. Diagnosis of epithelioma. Treatment asked.

Case III.—Bearded youth of 18, with swelling of right testicle. Cord felt above and normal. Swelling about size of Spanish nut connected with upper part of epididymis; cystic in nature; epididymis and testicle normal. Cord not felt below. Diagnosis, spermatocele. What else might it be? Encysted hydrocele of cord. Which do you think it is? Former. Why? What would you expect to be the features of its fluid contents?

Case IV.—Small boy lying on table with linear scar along front of tibia. What do you think was the matter with him? Acute necrosis, periostitis or osteo-myelitis. Ask the boy what was the matter with him. Under whose care were you (to patient)? "Dr. K——'s." Are you a Y——'s man (to candidate)? Have you seen this case before? What symptoms would such a case present? What would be the appearance of the limb? How would you treat it? What are the complications of osteo-myelitis? Is pyæmia a common complication? How would you distinguish osteo-myelitis from erysipelas? [*Bell.*]

Interval of *two hours*, during which candidates retire to lower room where they are imprisoned like criminals, although the inner man is allowed refreshment, provided by generosity of College authorities!

Surgical Anatomy, 7.30 p.m.

Mark out course of radial and ulnar arteries. Where does brachial artery divide? On what does the radial rest? Mark out the situation of the palmar arches.

What is the femoral ring? its relations? What is the femoral canal? How is it formed? What forms the constriction in a strangulated femoral hernia?

Candidate was shown the following instruments—*inter alia*—stone forceps, avulsion forceps, pile forceps, prostatic catheter. What are the features of prostatic catheter? Of what use is the large curve?

Candidate next shown a skull. Asked to point out position of mastoid antrum and lateral sinus. In what direction would you trephine to expose mastoid antrum? Bandage this man's leg, including the heel, for phlebitis. [*Bell.*]

Second Day.

Royal College of Surgeons, Lincoln's Inn.

Pathology—First Table, 5 p.m.

Specimen (i.) of trachea and larynx, pharynx and upper part of œsophagus laid open to show ulcerating growth of latter pressing on trachea. Following questions asked: —Usual situation of œsophageal growths; kind of growth; signs and symptoms of malignant stricture; onset, gradual or sudden; course; malignancy; cause of death when opening into trachea; and treatment. What kind of tube would you use? What symptom especially does gastrostomy relieve? What other kinds of œsophageal stricture do you know of? Give the causes of traumatic stricture? What treatment would you adopt?

Specimen ii.—Umbilical hernia. Does it ever become strangulated? What forms the constriction? [*Bell.*]

Second Table, 5.10 p.m.

Dry specimen of tibia and fibula amputated for malignant disease. Why is fibula removed entire and not sawn through below head as in case of tibia? Criticise the method adopted by the surgeon in this case. Does tibio-fibular articulation usually communicate with knee-joint? In this case it did, for patient

died through suppuration of knee-joint, following operation, which was performed in pre-aseptic days. What is this specimen? Tubercular testis. How does tubercle attack the testicle? Is the cord generally affected? Supposing tubercular testicle becomes healed, does testicle necessarily atrophy and become functionless? How would you recognise a case? and how treat it? Treatment in early and later stages given. What further examination would you make to satisfy yourself as to the extent of the mischief? Examine cord and vesiculæ seminales. [*Bell.*]

Present-day Neuroses: their Treatment.

By a General Practitioner.

Before Dr. Clifford Allbutt's valuable essay on "Nervous Diseases and Modern Life" appeared, I have thought a fruitful field lay before those who would study "Present-day Neuroses." This essay is valuable to us all, and some of us need it badly, as a nerve-tonic; but, like many such, which contain strychnine, phosphorus, and the like, it may become dangerous if taken too freely. It would seem that there is much to be said against the idea—which prevails in medical as well as unprofessional circles of all kinds—that nervous diseases, or at least nervous disorders, are increasing of late years. Dr. Allbutt's title is a little misleading, for he does not controvert the idea that organic nervous *diseases* are increasing, but that *neuroses*, and rightly so. This is the point at issue. Insanity, that debateable ground between definite lesions of the nervous tissues, and deranged or weakened function, occupying probably the territory of each, more or less, would seem, after all, not to be increasing in our midst. We are not told about the application of this view to France, Germany, Italy, Austria, the United States or the Colonies; but for the Anglo-Saxon race in its home, there is a message of comfort for the time being.

Neuroses, then, or derangements and weakness of nerve-function, or neurasthenia, are the subjects to which I would direct attention, and particularly as regards their treatment. If neuroses are not increasing beyond the growth of population in this country, they are at any rate marvellously common. I write as a general practitioner of some twenty years' experience in a varied practice of a great city and its environs, and can only say that, to my knowledge, neuroses visit, often on long visits, labourers and their wives, artisans and their wives, shop assistants, dressmakers, seamstresses, governesses, School Board teachers (male and female), high school teachers, clerks (male and female), domestic servants, philanthropic young ladies, slaves of fashion and pleasure, multiparous matrons, nulliparous matrons, with wonderful impartiality, and without any proper regard to their titled or lowly rank—but not irrespectively of their ancestry.

If possible, we should always study the historical side of things, but in the subject before us little history seems forthcoming. When we know the obscurity which surrounds the history of even definite and fatal diseases in early times, we cannot expect our sturdy ancestors to have left on record much information as to the aches and pains of neurotics, who must have agonized all through man's troubled history, when he had to maintain his delegated dominion over the lower creation, with rude weapons, and through mortal peril.

But passing over many a page of human history we hear little of disorders that do not kill. Unless the patient shortly survived his malady and its treatment, scant attention would be paid in early times, or even in the middle ages, to protracted diseases, and still less to disorders of long duration. The fear is that too many neurotics, because they did not die, must have been set down as devil-possessed, and neglect and ill-treatment would have been their portion. There would be little inducement of old to be a neurotic.

One notable and great man stands out in English history as the example for all time to neurotics—the Great Alfred—seized at the age of 19, at his own marriage-feast, with a dire internal pain, doubtless visceral neurosis, which tormented him for twenty years, and then wore itself out, but failed to wear out the noble courage, the fruitful energy, and unselfish devotion of one of the greatest kings in any country or any age. I know not if the late Sir Andrew Clark ever treated of this case in his encouraging addresses to the neurotic and delicate, in which he loved to urge them to make the most of their lives, but it was one worthy of him, and the words of Alfred in his later years would have furnished him an apt text—"So long as I have lived, I have striven to live worthily." I would here say that one of the signal benefits that great physician conferred on his generation was, by example first and eloquent precept next, to encourage the weak in health and nervous system to observe "physiological righteousness" and to make the most of their lives. It was a lesson deeply needed by the generation to which he spoke, and it should abide with us.

In the last century much satire and little sympathy was expended on what they called "the vapours," which was hysteria in its Protean manifestations, seen mainly among "the quality." This mysterious term included, no doubt, a due share of hysterical eclampsia, a form of neurosis, which, in passing I would note, has disappeared largely, as far as my experience goes, from the upper classes and descended to humbler ranks of life. I have noted this change even in my own time. These remarks as to the history of neuroses are hardly, of course, more than suggestions.

The *treatment* of neuroses has made a marked advance since I was a student.

As to *drugs*, I remember Dr. Fagge being somewhat distinguished among us students by such teaching as that many hysterical cases were *cured* by valerianate of zinc. It was then hardly the fashion to look for many cures of the cases. They have indeed been the opprobrium of medicine for many a generation, and many

pages of the Pharmacopœia would not have existed were it not for the faith in drugs for neurotics, so touchingly shown by themselves and their medical advisers. We have come to see of late years more clearly the power and the weakness of drugs for neuroses. Without such as iron, strychnine, phosphorus, quinine, valerian, zinc, and, lastly, bromides, we general practitioners would be badly able to treat the milder neuroses which infest our practices, and which we ought not and cannot treat nowadays in a cavalier fashion. The neurotics, as Dr. Allbutt says, have began to walk abroad like ghosts, and they want as well as need good treatment. As to bromides, in passing, we must remember how Dr. Wilks, with his vast experience, said he had never seen a case of illness or disease—I forget the precise terms—cured by bromides. This fact does not warrant one in depriving the poor neurotic, who is not yet a confirmed neurotic, of that beneficent fifteen grains of some bromide insinuated in his or her prescription, well disguised as to vehicle and (very easily by some of us) by hand-writing, which becomes the oil of life to him or her while sleepless, restless, worried and irritable.

Rest in bed, *change of scene*, *climate*, *occupation*, *hope*, *rebuke* will often, some or all, enter into the treatment of a case of obstinate neurosis. We are often painfully reminded in our struggles over such cases, of the rough surgery of Hercules upon the historic hydra, until the more drastic remedy of Iolaus was called in; which leads us naturally to the discovery—it can be called nothing less—of Dr. Weir-Mitchell, to which Dr. Playfair has so ably and largely contributed. We have learnt from that that severe chronic cases of neurosis or neurasthenia, formerly abandoned as hopeless, can be cured if they will. All of us know something of the epoch-making doctrines of Weir-Mitchell and Playfair as to *systematic treatment*, with its four strings to the bow, of which as many as he needs the experienced man will pull—*rest*, *full feeding*, *massage*, *electricity*.

We, as practitioners, and hundreds of condemned neurotics, owe a debt of gratitude to these two teachers. I have had some twenty cases, male and female, of intractable neuroses, which I have treated by this method, of which I am bound to say about half have failed, or succeeded poorly, and the other half have been notable successes; and I maintain that this class of success ranks highly. It will bring you many hours of preliminary discussions, six or eight weeks of frequent visits, often a signal success and much gratitude, and, when otherwise, more risk to your peace of mind and reputation than many an unsuccessful abdominal section; and yet it is right to give to every earnest neurotic the benefit of it, though to you the loss may be great and the benefit small. But this is the "badge of all our tribe," and one not to be lightly esteemed.

Beyond the valuable definite treatment recommended for neurasthenia, this discovery has, like all great *truths*, done as much good outside as inside its original province. To Dr. Weir-Mitchell and Dr. Playfair we owe it that massage now occupies its rightful place in medicine, and has been delivered from the hands of quacks. Further, the great underlying principle of this discovery, that neuroses depend for their cure primarily upon rest and better nutrition of the nerve-tissues, whatever the exact means we may employ, is modifying the treatment of every enlightened practitioner to-day. This was far otherwise 17 to 20 years ago, when so often in these cases medical nihilism, with mere drugging, uterine specialism, and neglect, "held the field."

We have learnt the value of:—

(1) Complete rest.
(2) Rest alternated with exercise.
(3) Exercise of muscles, varied and *limited*.
(4) Exercise of mind, varied and *limited*.
(5) Passive exercise versus active exercise.
(6) Regulated frequent small meals, combined with some of the above methods.

These and other principles have taken definite form in the minds of most practitioners, through the doctrines of Weir-Mitchell and Playfair, and their sphere has spread beyond that of neurasthenia.

Finally, for the curable and serious-minded neurotic, that part of his treatment which character will effect, can never be expressed better than in the noble words of Tennyson: "Self-reverence, self-knowledge, self-control—these three alone lead life to sovereign power."

When all has been done and said, there must remain only too large a number of neurotics whom we cannot cure, often for reasons hidden from us, but not from themselves, and to such Dr. Goodhart addressed wise words in his lectures on the treatment of neuroses, when he urged them to bear quietly as much of their miseries as could not be cured, which may be summed up in our message to them "to withstand in the evil day, and, having done all, to stand."

Blackheath. WALTER KIDD.

Appointments.

Cooper, C. E., M.B., B.C. Cantab, has been appointed House-Physician to the City of London Hospital for Diseases of the Chest, Victoria Park.

Burghard, Frederic F., M.S. Lond., F.R.C.S., has been appointed Surgeon to Out-patients at the Paddington Green Children's Hospital.

Gill, J. M., M.D. Lond., L.R.C.P., M.R.C.S., has been appointed Honorary Assistant Physician to the Sydney Hospital, New South Wales.

Poland, John, F.R.C.S. Eng., has been appointed Surgeon to the City Orthopædic Hospital, *vice* E. T. Chance, deceased.

Thorne, J. M., L.R.C.P. Lond., M.R.C.S., has been appointed Consulting Surgeon to the Retford Cottage Hospital.

We regret that by a clerical error in announcing an appointment of Dr. S. R. Alexander in our last issue, his qualification should have been given as M.B. instead of M.D. London.

Passim.

At the end of his lecture on the last Thursday of the Winter Session, Mr. Jacobson announced that he had resigned the post of Lecturer on Anatomy, an announcement which we are sure will be received with regret by all those who have attended his lectures. Mr. Jacobson said that other duties prevented him sparing the time which the preparation of such lectures demanded in a large school like Guy's, and the black boards, when Mr. Jacobson is lecturing, bear witness to the care and patience he has bestowed on them, often late at night, or in the early morning, when those who listen to him were—perhaps happily—unconscious of even the existence of anatomy.

To make the study of anatomy easy is perhaps beyond human capabilities, but all Guy's men will agree that Mr. Jacobson never failed to make even the driest parts interesting, and we regret that our successors will not have the same opportunities as we have had (alas! had we but used them better!) of gleaning many useful facts which are not to be met with in the ordinary text-books, and which show the practical bearing of what we might otherwise consider as cumbersome knowledge.

Our readers will be pleased to hear that F. E. Beddard, Esq., M.A., F.R.S., R. Clement Lucas, Esq., M.B., B.S., W. Hale White, Esq., M.D., and Peter Horrocks, Esq., M.D., have been appointed Examiners in Comparative Anatomy and Zoology, Anatomy, Materia Medica and Pharmaceutical Chemistry, and Obstetric Medicine respectively at the University of London.

It will also afford great satisfaction to Dr. J. McD. Gill's friends to learn that he has been appointed Hon. Assistant Physician to the Sydney Hospital. Our readers will remember that Dr. Gill was at one time Surgical Registrar to this Hospital.

We are requested to note that the Biology classes for the Preliminary Scientific Examination will be held on Wednesdays and Fridays during the Summer Session, and not on Tuesdays and Thursdays as previously announced. The first class will be held on Friday, May 3rd, at 10.30 a.m.

The attention of Dental Students is directed to the following regulation which will come into force at the next examination for the Licence in Dental Surgery, namely:—"A candidate, who is referred at the examination for the Licence in Dental Surgery, will be required to produce, before admission to re-examination, a certificate of three months' additional study at a general hospital and a special dental hospital, the precise attendances required at each hospital being left to the discretion of the respective hospital authorities."

The next Primary and Final Examinations for the Diploma of F.R.C.S. will commence on Thursday, May 9th, and Monday, May 20th; the next examination for the Licence in Dental Surgery on Friday, May 10th. Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these examinations.

There are, among the ever-increasing number of "doing good" societies some which are performing useful work in a manner that escapes general notice. In this category the Church Lads' Brigade must be included, and by obtaining a hold upon the young of our working-classes, the executive of this Brigade are doing national good. As an instance of their activity and enterprise, a Medical Staff Corps has been established, and, judging from its manual, which we have lately received, we may premise that those "lads" who volunteer for the purpose are well trained to render First Aid. Medical men, by offering their services as surgeons to the Church Lads' Brigade, have thus an opportunity of materially aiding this flourishing Institution "in that very useful branch of their work, Ambulance and First Aid."

The Clubs' Union Ground is just now in very excellent condition, and with the advent of the Cricket and Lawn Tennis Season has already received considerable patronage. Both Cricket and Lawn Tennis Clubs are, we understand, in want of new talent, and we are sure that the Hon. Secretaries will be glad to hear from any freshmen who are desirous of getting their "blues." At the same time we would remind intending débutants that the best way to obtain recognition as players is by availing themselves of the many opportunities for practice which our first-rate ground affords them.

We understand that a movement is on foot to establish a Lawn Tennis Club for the Nurses. It will be a matter for congratulation if the Council of the Clubs' Union can see their way to sanction the proposal (emanating, we believe, from the Guy's Hospital Lawn Tennis Club), that several Courts at Honor Oak should be placed at the disposal of the Nursing Staff between the hours of 10 and 12 on three mornings of the week.

An event of considerable local importance recently took place, when the St. Saviour's Public Swimming Baths were opened to the public. The buildings are situated in Lavington Street, Southwark. The first-class bath has a clear water space 100 feet long and 30 feet wide, and there are diving boards fitted at one end, which is six feet six inches in depth. One of the baths is to remain open throughout the year, and the first-class bath is reserved for ladies every Tuesday from 9 a.m. to 1 p m. Tickets of admission can be most advantageously purchased by taking a quantity at a time. The Baths are so conveniently situated for the Hospital, as to naturally invite the patronage of every one at Guy's. We understand that Mr. V. E. Collins, Hon. Secretary of the Swimming Club, is now making inquiries as to the advisability of establishing our head-quarters there. There should be no difficulty in accomplishing this, and we may look for considerable improvement in the condition of our club. We may also confidently look forward to the formation of a thoroughly efficient polo team to represent us in the United Hospitals' competition.

We have already drawn attention to the proposed formation of a Nurses' Lawn Tennis Club. An opportunity now presents itself to its promoters to take unto themselves the perhaps more difficult task of organising a swimming club. We are sure that the Guy's Hospital Swimming Club will be pleased to render any assistance which may be desired to this end.

It was with peculiar regret that we became conscious of an omission in the last issue of the Gazette. Among the names of the going-off Residents there should have appeared that of Mr. E. F. H. Hardenberg.

During Wednesday last, a number of children were treated in the front surgery for symptoms of poisoning, which consisted of vomiting, with a slight amount of depression and collapse. It was found that they had, all of them, been eating some seeds, the true nature of which has not yet been discovered, but which the children themselves styled "cocoa-nut beans."

The "Parsons" Testimonial Fund has only reached the sum of £10 10s. The intention is to close the list on Saturday next, May 4th, and in the meantime the Smoking Room attendant has been authorised to receive further donations. We feel sure there must be many who will desire to see the above moderate sum substantially increased. The Librarian desires to acknowledge a donation to the fund of 5s. from Dr. C. R. A. Sutton.

We rejoice that the road leading to the Maze Pond Entrance is at length, after many months' building operations in its immediate neighbourhood, beginning to assume its wonted appearance, and that the miniature mountain of bricks and earth is slowly, but surely, being cleared away. In connection with the building work which is being carried on at the Newcomen Street end of the Hospital, it is of interest to note that portions of a full-sized skeleton were unearthed the other day.

We are also glad to see that the Park fountain has received an ornamental iron fencing, and the latest we hear is that the lower basin is to become the habitation of various members of the finny tribe.

From two points of view:—

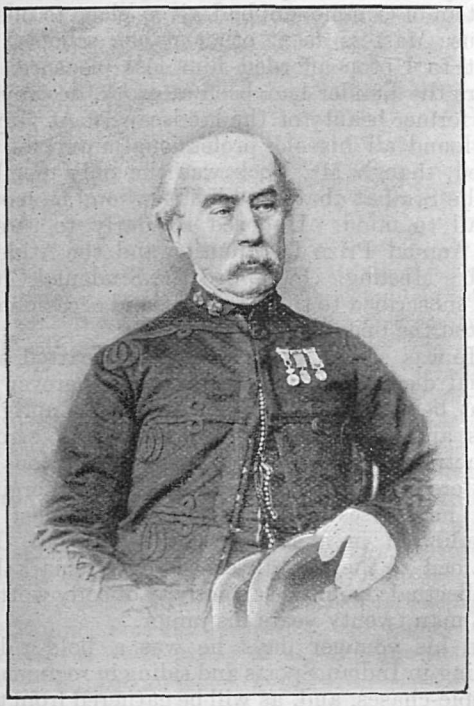
> "Primrose Day was observed at Guy's with the greatest enthusiasm. Large numbers of the men wore buttonholes of their revered leader's favourite flower, while many of the wards were lavishly decorated with the same emblem."

> "The observance of Primrose Day—so-called—at Guy's is fast dying out. It is true that a few misguided individuals were vain enough to sport bouquets of primroses—a flower which they are dimly conscious is to be worn on that day in memory of a one-time leader. A sprinkling of the same flower—really but an emblem of Spring—was to be seen in a few of the wards."

The Artists' Corps will parade at Guy's Hospital to-day (Saturday), at 3.45 p.m., and proceed by train from London Bridge to Woolwich.

Obituary.

Surgeon-General SAVILLE MARRIOTT PELLY, C.B., F.R.C.S.



Surgeon-General Pelly, who died on April 3rd, at Woodstock House, Lee, Kent, was the last surviving son of the late Judge John Hinde Pelly, of the Indian Civil Service, and a brother of the late Major-General Sir Lewis Pelly, K.C.B., K.C.S.I., M.P. He was one of seven sons, six of whom reached the age of manhood and entered one or other of Her Majesty's services, three attaining to the rank of general officers. Born in India, he was sent to England for education, and made his home at Upton in Essex, with his cousin, Sir Henry Pelly (the President of the Hudson Bay Company), after whom Fort Pelly, the Pelly River, and Lake Pelly, in North America, take their names. He was placed at Winchester, where, owing to the marvellous faculty he had of getting out of scrapes he received the nickname of "Proof Pelly." As an instance of the good luck which never deserted him, he used to relate how that once, when staying with friends in Gloucestershire, he took compassion on a poor stray dog that had found its way into the grounds. Whilst in the act of fondling it he was startled by the arrival of the whole country side, armed with guns and staves, in search of this very dog, which was mad and had already bitten several persons, but left him uninjured.

It was at Winchester that he first showed his courage and self-reliance by saving two of his school-fellows from drowning. One of these, when bathing, was carried through the sluice-gates of the canal into the deep lock below. Pelly immediately plunged in after him and managed to keep his head above water till assistance arrived. Another was caught in some weeds in the River Itchen, and Pelly, at some risk to himself, swam out and succeeded in extricating him. He is credited with the saving of five lives by his swimming; one of these was a brother, whom in later years he pulled out of the River Indus.

On leaving Winchester he began his medical education at the Bristol Royal Infirmary, where he was for some years dressing-pupil under his uncle, Mr. Richard Smith, at that time the senior surgeon. He next entered as a student of Guy's Hospital at the time when Bright and Addison were physicians, and Astley Cooper was still alive. It is interesting to note that Dr. J. G. Swayne, whose name is so intimately associated in all our memories with the Bristol Medical School, was a fellow student of Pelly both at Bristol and at Guy's. He was a student when Sir Astley Cooper died in 1841, and was one of those who lined the way to the hospital chapel, in a vault of which the body of that distinguished surgeon is deposited. After finishing his professional studies he entered the Indian Medical Service, and was soon ordered to the front. He was present in July and August, 1843, with a field-force under Major Blood in the southern parts of Sind, and served with the Sind Irregular Horse during Sir C. Napier's campaign in 1844–5 against the predatory tribes on the borders of Cutchee, and in the surprise and capture of Shahpoor on the night of January 15th, 1845, being favourably mentioned in despatches by Captain Jacob. He was present with the army of observation at Bhawalpoor under Sir C. Napier in 1846–7, and with the Sind Horse during the pacification of the frontier of Sind in 1847–8 under Major (afterwards General) John Jacob. He served with the 2nd Regiment of Light Cavalry in Rajpootana during the Mutiny campaign in 1857–8, and was present as senior medical officer at the attack on Nimbhaira, the action of Jeerun, and throughout the siege of Neemuch under Captain Simpson, joining afterwards in the pursuit of Tantia

Topee with the column under Brigadier Parke. At the conclusion of the war he received the Indian medal and clasp for Central India. For many years he was resident in Sind, and when he was moved on to Poona the *Sindian* of that date contained the following paragraph: "Dr. Pelly will be much missed in the circle he leaves to-day. He is one of the oldest residents among us, having seen service since about the year 1844. He knows the country thoroughly, and has watched the progress of its various communities from the first. We still entertain a hope that he may again return to Sind, where he is so well known and so universally popular." As he rose in his profession he became Inspector of Prisons in the Bombay Presidency, and at his suggestion the Government introduced gardening as prison labour, whereby a great saving was effected; for not only was the health of the prisoners greatly benefited by this open-air exercise, but all the vegetables required by the inmates were thus obtained without purchase. When the Abyssinian expedition was determined upon he was selected for the post of principal medical officer of the Indian Medical Department, and he served throughout the campaign in 1867–8 under Sir Robert (afterwards Lord) Napier. For his services during this expedition he was recommended for the K.C.S.I., but as it was found that this knighthood could only be conferred for services rendered in India he was rewarded by a Companionship of the Bath.

The *British Medical Journal* of that date contained the following passage:—"The arrangements in Abyssinia of the two services were conducted separately by their respective medical departments, and, we believe, well conducted. Deputy Inspector-General Pelly of the Indian Service had a difficult task and fulfilled it, by all accounts, most successfully."

Having risen in his profession to be Deputy Inspector-General of Hospitals in the Bombay Presidency, he retired as Inspector-General in 1870. After his retirement he lived for many years in Dublin, but came to London a few years ago to be near his two surviving brothers, Sir Lewis Pelly (at that time representing Hackney in the Conservative interest), and General Pelly, who married his wife's sister, and was living at Hereford. His eldest son also had been appointed to a living in Derbyshire, and this formed an additional reason for his settling in England.

At the quincentenary festival of Winchester College, held two years ago, Surgeon-General Pelly was among the oldest of the Old Wykehamists present, and this visit to the scenes of his boyhood afforded him the keenest sense of pleasure. Even on this old foundation he found changes had taken place, among others, the old system of Commoners had given place to one of House-Masters as at other public schools. A visit to Upton afforded him less pleasure, for there the builder had been at work, destroying the former beauty of the landscape. At Guy's, he found all his old professional interests revived, though Mr. Cock was the only member of the Staff at that time living whom he could recall to mind. He used regularly to attend the Annual Prize Distribution and the Athletic Club's Meeting. He joined the Students' Club, and subscribed to the Gazette, and occasionally visited the operating theatre.

He was a man of a most warm-hearted and genial disposition, making friends wherever he went, being universally respected for his uprightness and gallantry. Firm in will and strong in action, brave and courteous, punctilious in matters of honour, yet kind, gentle and forgiving, he possessed all the qualities most to be admired in a soldier and a surgeon. He retained to the last an exceedingly remarkable intellectual vigour and an activity of body worthy of a man twenty years his junior.

In his younger days he was a bold rider, joining in Indian Sports and riding in regimental steeple-chases, and, as will be gathered from the foregoing account, most of his earlier military service was in association with cavalry.

In his retirement, having always had a strong taste for engineering, he amused himself chiefly in his workshop turning out all kinds of articles, useful and ornamental. Among other things he made an electric clock, every part of which he put together with his own hands, and he had been at work at an electric stethoscope which was to enable every member of a class to listen to the same heart whilst the physician was demonstrating its defects. He enjoyed perfect health until five weeks before his death, when he was first seized with angina pectoris, associated with some fever, apparently influenza. Dr. Green, of Lee, who attended him, discovered a mitral bruit and gave him relief by medicine and rest; but attacks of cardiac asthma became frequent, and a week before his death Dr. Pye-Smith saw him in consultation. He died suddenly (as had been thought probable), whilst sitting in his chair, on Wednesday, April 3rd, aged seventy-six. He leaves a widow, two sons (the Rev. Stanley Pelly and Captain Saville H. Pelly), and two daughters.

On the Zambesi in a Gunboat.

(*Concluded.*)

In January, 1894, both the gunboats started from Chinde to explore the upper portion of the Zambesi above the junction of the Shiré river, this being the first occasion that the white ensign had appeared in this part of the world. The river here was found to be about two miles in breadth, but progress was slow on account of numerous sand banks and want of fuel. Both banks of the river are under the rule—or misrule—of the Portuguese, and the half-castes who represent this nation were by no means favourably disposed, and refused to sell us any fuel. Consequently every available man from both ships had to be landed every alternate day to cut wood for the next day's steaming. Relations between the Portuguese and the natives appeared to be decidedly strained. The flag of Portugal floated over numerous small stations on the banks of the river, every one being defended on the land side by a double stockade—with field or machine guns mounted therein, and guarded night and day by sentries. This was necessary, we were informed, on account of the ferocity of the natives. No Portuguese dare leave his fort for fear of being massacred, and the stockades have more than once been destroyed by the natives, usually by a night attack. However, although they had plenty of opportunities, they never molested us in any way. Occasionally, on seeing the ships, they would bolt into the bush, but, on hearing we were English, generally reappeared, and would sit for hours on the banks gazing at us with open-mouthed admiration. The prevailing impression seemed to be that we had come to fight the Portuguese. In fact, one white-headed wrinkled old man, who said he was the chief of the district, came to visit us in state, riding on a man's shoulders, attended by a numerous retinue of both sexes. He said he remembered Livingstone, and that if we would only give him a little powder for his men the Portuguese should forthwith be driven out and their "kraals stamped flat." He looked much disappointed when we told him the Portuguese were our friends, and that we could not possibly assist him in his project.

Several shooting excursions were made in this part of the country, game being plentiful, and so successful were we that the grateful natives entitled us the "meat providers." The meat was the more acceptable to them as the locusts had devastated their crops. Hippotami were very numerous, as many as 30 being seen in one herd or "school." Buffalo were abundant in herds of 400–600, and there were plenty of antelope and zebra. Fresh spoor of elephant and rhinoceros were seen, and lions were frequently heard roaring at night—a sure sign of the presence of game.

One sporting bluejacket nearly got his quietus from a buffalo. He wounded the beast twice with his Martini rifle and it then fell down, and he walked up to it thinking it was dead; when only a few yards off it got up and charged. His rifle being empty he bolted, the buffalo after him, and he would probably have come off second best had not his chum made a very bad but very lucky shot. He was about 40 yards off and took aim at the animal's head and broke his hind fetlock, bringing it down all of a heap. The natives then stuck assegais into it until it succumbed. Nearly all accidents from wounded buffalo have occurred in this way, several sportsmen having fallen victims to these brutes, whose tenacity of life is simply marvellous. Some hunters go so far as to say that a wounded buffalo is the most dangerous of all animals. Another animal which is extremely hard to kill is that ungainly creature, the Lichenstein's Hartebeest. One of these had ten express bullets in its body and one through the base of the horn, and was still going strong, when a bullet in the neck dropped him dead. Even the smaller antelope, when shot through the heart, will go off at full gallop for 100 or 150 yards and then fall head over heels stone dead. Where the grass is high animals are apt to be lost in this way unless carefully tracked. Herds of that graceful antelope, the pallah or impala, abounded everywhere, and, although very swift and keen-scented, fell an easy prey to the rifle on account of their insatiable curiosity. When once alarmed the leading buck gives a shrill whistle, and the whole herd go off at a tremendous pace, leaping high over any obstacles in their path. However, they seldom go far, and soon one or two of them turn round and begin trotting back again to investigate the cause of the disturbance, and afford the sportsman an easy shot if he has kept himself well hidden. All hands turned out in pursuit of game, as we found that the natives would cut fuel for us to any extent if the meat was given to them.

In this way we reached the Lupata narrows, where the river runs through a range of hills; although two miles broad below and above, the river is only 100 yards in breadth in the narrows and the current is consequently very strong. Steaming at full speed we just, and only just, managed to hold our own, doing the twelve miles in about eight hours. Once through the narrows we experienced no further difficulty, and arrived at Tete on 4th February, the distance from Chinde being nearly 300 miles.

The Portuguese town of Tete is 300 years old, and is said once to have been in a flourishing condition, but now it is in a wretched state, the principal buildings being in ruins. The Portuguese were in a great state of excitement at our arrival. "Had we the Governor of Mozambique's permission to visit Tete?" "No, we had not, and had no intention of applying for it." The population of Tete were then called to arms and the forts hurriedly repaired, and antiquated smooth bores mounted and pointed at us. These proceedings were a source of great delight to our men, who used to sit round and smoke, their remarks being fortunately unintelligible to these warlike people.

One field-piece (about 100 years old) which they mounted on the bank immediately above us, was invariably found overturned in the morning. Although the

Commandant offered a reward of several thousand milreis in paper money the culprit was never discovered. When the fort was finished they determined to fire a salute to their Governor to show us at the same time how powerful an armament they had. At about the sixth gun the whole of one angle of the fort collapsed, burying several of the guns in the rubbish. After this catastrophe they threw up the sponge and sent us a fine bullock as a peace offering, which we magnanimously accepted, and he was forthwith killed and eaten, in case they should change their minds and want him back again.

After this we spent a very pleasant time at Tete. There being no tse tse fly oxen were abundant and cheap. One sheep or eight fowls for a rupee (which is practically a shilling), and 8 eggs for a penny, cannot be called an exorbitant tariff.

At the end of the rainy season we left Tete once again for Chinde, our store depôt. The end of the rainy season was a most trying time, and we all got doses of fever or dysentery, especially after getting back to the mouth of the river, where the sea breeze felt quite chilly.

Taking it all round, it must be acknowledged that the climate of the Zambesi is one of the most trying in the world. To a man who is not a sportsman or botanist or geologist the station has absolutely nothing to recommend it. Our bluejackets especially suffered severely, and I have little hesitation in saying that those who reached home will have good reason to remember their commission on the Zambesi River for a long time to come.

Portsmouth. J. DOWSON, Surgeon, R.N.

Reviews.

Text-book of Anatomy and Physiology for Nurses. Compiled by Diana Clifford Kimber, Assistant Superintendent New York City Training School (New York, Macmillan & Co.). Price 10s. net.

This volume may be described as a brief account of the anatomy and physiology of the human body. It has been carefully compiled from standard text-books, and, for the most part, discrimination has been employed in the selection of the material. As a book of reference we have nothing but praise for the volume before us; the diagrams are excellent and well chosen, whilst the matter is clearly expressed. As a text-book, however, we think that something much more elementary, much less pretentious, and much more interesting, would have been infinitely more useful.

A Hand-book of Hygiene. By A. M. Davies, Surgeon-Major, A.M.S.; late Assistant Professor of Hygiene, Army Medical School, Netley (London, Charles Griffin & Co., 1895). Price 12s. 6d.

Surgeon-Major Davies is to be warmly congratulated upon the result of his labours. The subject is treated in a very complete manner, and with a careful balancing of the views of different authorities. The section dealing with the examination of water may be mentioned as being an especially valuable one; it gives a careful and detailed account of the bacteriological methods in use in the investigation of potable waters. The chapters devoted to a discussion of the "causation and prevention of disease" are the most discursive, and therefore the most interesting; this is especially true of the pages dealing with the variability of bacteria. The book has a distinct charm of its own, in that every page bears evidence of the fact that the author is himself keenly interested in the subjects upon which he is writing. Further, good binding, fine paper, and clear print add very much to the pleasure in reading any book, and in these respects the publishers have done their part well.

A Contribution to the Pathology of the Vermiform Appendix. By T. N. Kelynack, M.D., Pathologist to the Manchester Royal Infirmary; Demonstrator and Assistant Lecturer on Pathology in the Owen's College (London, H. K. Lewis). Price 10s.

We have received from Messrs. Lewis a copy of Dr. Kelynack's valuable monograph. As the book was published in 1893, it has been so long before the profession that it hardly needs a review. We would, however, like to direct to it the attention of any of our readers who have not seen the work, since it presents a most complete résumé of our knowledge of the subject up to that time; it contains also an exceedingly full and valuable bibliography.

A Manual of Obstetric Nursing. By Marian Humfrey, British Lying-In Hospital, Diploma London Obstetrical Society, Member of the R. B. N. A., and of its Registration Board. (Sampson Low, Marston & Co.)

This work, which is a comprehensive treatise on that all-important duty of a scientific and efficient nurse in "Child-bed Nursing," is dedicated to H.R.H. the Duchess of Teck. The authoress has written it "with a two-fold object: to raise the position of this portion of the nursing art, and to awaken in the minds of my countrywomen of all ranks of life a sense of its extreme importance to mothers themselves." To whatever extent, and we are aware how great that has been, this branch of nursing has been the most neglected and despised, the work under notice, to our mind, grapples with the subject in a thoroughly extensive and bold manner. There have been, from time to time, many valuable books published on obstetric nursing; however, no apology is needed for the introduction of Miss Humfrey's work. It has the most practical bearing on the subject, and we can commend it to our own nurses as a valuable adjunct to their nursing library. The manual is divided into two parts. In Part I. the authoress has given her readers an exhaustive number of practical points on the "Maternal" side in respect to duties before labour, during labour, after delivery, and during convalescence, lactation, and the lochial period. In this part of the work we were struck with the very

excellent methods the authoress lays down for the nurse, and she is happily most strict in regard to feeding and cleanliness. In some particulars Miss Humfrey has expanded to an unnecessary extent, but she is so full of her subject that perhaps some excuse must be allowed her.

Part II. treats of the "Infantile" side, which is perhaps the most often neglected by obstetric nurses. Practical and practicable rules are laid down for the guidance of the nurse. Such as are required in the skilful handling of an infant, in its washing and dressing, and of its *first* feeding. We noticed that Miss Humfrey has drawn particular attention to the question of "baby's eyes." "The care of the eyes begins at the moment of birth when they should be wiped with a soft napkin *as soon as the head is expelled*, and, if possible, before the eyes are opened." And the authoress further urges the importance of using distilled water for bathing. "Infantile Feeding" receives a great amount of well-deserved attention, and a chapter on "General Duties" brings to an end a work which, if at times somewhat heavily worded, and of which its theoretical auguments are not always clear, will none the less be found of value and use to all obstetric nurses. It is a matter of considerable regret that in the volume we have reviewed there should be absent a ready index; doubtless this fault will be remedied in the next edition.

Correspondence.

To the Editor of Guy's Hospital Gazette.

A Warning.

Sir,—Mr. A. E. Durham, of Brook Street, has written me that he has been applied to for pecuniary assistance by a person describing himself as Alfred Gillingham, of Guy's Hospital. Fortunately, Mr. Durham knew me, and so knew the person was an impostor.

I should feel obliged to you if you would bring these facts to the notice of Guy's men, old and present, so that should the rascal apply in my name to them for help, they will not only not give it, but hand the applicant over to the police. Faithfully yours,

Chiswick. ALFRED GILLINGHAM.

Cricket: "Past *v.* Present."

Dear Sir,—May I through your widely-read columns inform old Guy's men that the Annual Cricket Match between Past and Present Guy's men will take place this year on the 8th (eighth) of May, so that the names of all those anxious to take part on behalf of the "Past" should be sent to me at 55, Warwick Road, Maida Vale, W., without delay. Thanking you in anticipation. I am, Sir, yours obediently,

W. J. SCOTT.

Pass List.

First Conjoint Examination, April, 1895.

(Under Regulations dated January 1st, 1892.)

Elementary Anatomy and Biology.

Bagshawe, H. V.
Barlow, E. H.
Browne, T. W. S.
Cawston, A. E.
Dismorr, H. B.
Evans, S. J.
Goble, E. W.
Loosely, W. H.
Mitchell, E. P.
Muir, B. W.
Rodil, J. J.
Scott, E. F.
Simpson, G. S.
Smith, A. A.
Talbot, A. W.
Thomas, W. M.
Wright, T. J.

Elementary Anatomy only.

Atkins, J.
Brockwell, J. B. C.
Brook, F. W.
Bryan, C. A. D.
Davies, A. G. C.
Denny, H. R. H.
Densham, A.
Foster, H. B.
Higgens, H. A.
Morris, H. E.
Moss, B. W.
Munro, D. J.
Osborn, A. G.
Ransford. A. C.
Reeve, H. M.
Rutter, T. F.
Secretan, W. B.
Segreda, F. A.
Stevens, W. A. G.
Stewart, W. G.
Swan, R. H. J.
Turner, F. D.

Elementary Biology only.

Edwards, C.
Hicks, C. E.
Hope, W. B.
Kelly, T. T.
Lee, C.
McLachlan, A. R.
Shorland, G.
Thomas, A. M.

Chemistry and Physics.

Barron, R. M.
Carr, H. B.
Johnson, W.
Palmer, W. G.
Perks, A.
Sells, C. B.
Ward, P. H.
Wright, T. J.

Practical Pharmacy.

Bryan, C. A. D.

(Under Regulations dated October 1st, 1884.)

Elementary Anatomy and Physiology.

Bridger, J. D.
Dunston, J. T.
Hutchinson, F. E.
Plumley, A. G. G.
Rae, F. L.

Chemistry and Physics.

Oliver, N. H.

Materia Medica and Pharmacy.

Marsh, H. R.
Prebble, E. A.
Rowland, L. T. A.
Smith, H. V.
Todd, D. B.

University of Cambridge, April, 1895.

Examination for the Diploma in Public Health.

Eyre, J. W. H., M.B., B.S. Durham.
Jewell, J. W. F., M.D., B.S. Lond.

University of St. Andrew's, 29th March, 1895.

Examination for the Degree of Doctor of Medicine for registered Medical Practitioners.

Shadwell, St. C. B., L.R.C.P. Lond., M.R.C.S., D.P.H. Eng.

Royal College of Surgeons of England.

The Collegial Triennial Prize.—Consisting of The John Hunter Medal executed in Gold to the value of Fifty Guineas, or, at the option of the successful Author of the Dissertation, of the said Medal executed in Bronze, with an honorarium of Fifty Pounds. The subject of this Prize is—"The arrangement and Topography of the different parts of the Gastro-intestinal Canal in Man, with special reference to the Variations in their relation to the Peritoneum and the occurrence of Abnormalities; the Subject to be illustrated from Development and a Comparison with the customary arrangement in other Mammalian Animals."

Jacksonian Prize (the Amount of the Dividend, about £12, received from the Trust).—The Subject for the Prize for the present year, 1895, is—"Tetanus." The Subject for the Prize for the ensuing year, 1896, is—"The Pathology, Diagnosis, and Treatment of Diseases of the Prostate Gland."

The Prizes are to be written for under the following conditions:—

Candidates to be Fellows or Members of the College, not on the Council.

The Dissertations to be in English, and the number and importance of original facts will be considered principal points of excellence:—*recited cases to be placed in an appendix.*

Each Dissertation to be distinguished by a motto or device; and accompanied by a sealed envelope containing the name and residence of the Author, and having on the outside a motto or device corresponding with that on the Dissertation.

The Dissertations to be addressed to the Secretary at the College.

The Manuscript Prize Dissertations and every accompanying drawing and preparation will become the property of the College.

Those Dissertations which shall not be approved, with their accompanying drawings and preparations, will, upon authenticated application within the period of three years, be returned, together with the papers, unopened, containing the names and residences of the respective Authors.

The unapproved Dissertations which shall remain three years unclaimed, with their accompanying drawings and preparations, will become the property of the College; at which period the papers containing the names of the Authors will be burnt, unopened, in the presence of the Committee.

The Dissertations for the Collegial Prize must be delivered at the College not later than 4 o'clock p.m. on Friday, the 31st of December, 1897.

The Dissertations for the Jacksonian Prize for the present year, 1895, must be delivered at the College not later than 4 o'clock p.m. on Tuesday, the 31st of December next.

The Dissertations for the Jacksonian Prize for the ensuing year, 1896, must be delivered at the College not later than 4 o'clock p.m. on Thursday, the 31st of December, 1896.

EDWARD TRIMMER, *Secretary.*

4th April, 1895.

Society of Apothecaries of London.

Syllabus of Three Lectures entitled, "An Introduction to the Study of Micro-Organisms in their Relation to Disease," to be delivered in the Hall of the Society, Blackfriars, on Tuesdays, 23rd and 30th of April, and Tuesday, 7th of May, at 4 o'clock each day, by Professor Charles Barrett Lockwood, F.R.C.S. Eng., Assistant Surgeon to St. Bartholomew's Hospital; Hunterian Professor at the Royal College of Surgeons of England; Examiner in Anatomy to the Society of Apothecaries of London, etc.

April 23rd.—First Lecture. Historical.—Classification of Bacteria.—Structure and Physiology of Bacteria.—Cultivation of Bacteria.—Fermentation.—Products of Activity.—Distribution of Bacteria.—Sterility of healthy Tissues.—Saprophytes and Parasites.—Requirements of Koch and Henle.—Value of experimental Pathology.—Disinfection and Antisepsis.—Disinfection by Heat and Chemicals.

April 30th.—Second Lecture. Micrococci.—Classification and general characters.—Staphylococcus pyogenes aureus and albus.—Streptococcus pyogenes seu Erysipelatis.—The relation of Bacteria to suppuration.—Immunity, natural and acquired.—Pyæmia and Septicæmia.—Consecutive infection.

May 7th.—Third Lecture. The Bacilli.—Putrefactive Bacilli.—Bacillary Septicæmia.—Bacillus Coli Communis.—Typhoid Bacillus.—Peritonitis.—Bacillus Pyocyaneus.—Bacillus Septicus.—Bacillus of Tetanus.—Bacillus Anthracis.—Bacillus of Tubercle.—Methods of Infection.—Organization of operations.

JAMES R. UPTON, *Clerk.*

There are a few tickets to be had on application to the Librarian.

Metropolitan Asylums Board.

MEDICAL INSTRUCTION AT FEVER HOSPITALS.

NOTICE TO STUDENTS.

A Course of Instruction in the Diagnosis and Treatment of Fevers will be held at each of the undermentioned Hospitals as follows:—

EASTERN HOSPITAL, The Grove, Homerton, E. (Dr. E. W. Goodall, Resident Medical Superintendent), on Tuesdays and Fridays, at 11.0 a.m., commencing Tuesday, 7th May, 1895.

WESTERN HOSPITAL, Seagrave Road, Fulham, S.W. (Mr. R. M. Bruce, Resident Medical Superintendent), on Tuesdays and Fridays, at 11.0 a.m., commencing Tuesday, 7th May, 1895.

SOUTH-WESTERN HOSPITAL, Landor Road, Stockwell, S.W. (Dr. F. F. Caiger, Resident Medical Superintendent), on Tuesdays and Fridays, at 11.0 a.m., commencing Tuesday, 7th May, 1895.

SOUTH-EASTERN HOSPITAL, Hatfield Street, New Cross, S.E. (Near Old Kent Road Station, L. B. & S. C. Railway) (Dr. J. MacCombie, Resident Medical Superintendent), on Tuesdays and Fridays, at 11.0 a.m., commencing Tuesday, 7th May, 1895.

N.B.—Students desiring to attend a Course of Instruction are required to bring their authority from the Dean of the School to the Clerk of the Metropolitan Asylums Board, Norfolk House, Norfolk Street, Strand, W.C., on any week-day (except Saturday) between the hours of 11.0 a.m. and 4.0 p.m.

The fee for the Course of Instruction is £3 3s. for two months, and £1 1s. for each month afterwards; and Students will be required to observe the Rules and Regulations laid down for their guidance by the Local Government Board and the Metropolitan Asylums Board.

Appointments.

DUTIES TO COMMENCE ON MAY 1ST, 1895.

Clerks to Anæsthetists.—Messrs. W. F. Byford, H. R. T. Fort, T. L. Jackson, L. C. Panting, A. E. Philipps, F. W. Rowland.

Externs.—Messrs. H. Alexander, C. Coventry, P. J. Curtis, B. B. Ham, T. W. Stanton, F. G. Thomas, W. Tyson.

Dental Appointments.

Curator in the Dental Laboratory.—Mr. E. E. D. Heesom.

Dressers in the Gas Room.—Messrs. E. Ashby, E. D. Bascombe, H. C. Cowles, J. L. Payne.

Dressers in the Ordinary Extraction Room.—L. Bidlake, E. B. Dowsett, A. G. G. Plumley, G. S. Simpson, N. Snell, E. W. Smith.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G. K., BATTLE.—The culture shows a profuse growth suggesting diphtheria. Microscopic examination reveals the presence of the bacillus diphtheriæ associated with staphylococci, large bacilli and other bacteria.

E. R. M., HASTINGS.—No tubercle bacilli could be found in the sputum.

MACI., S. PETHERTON.—No tubercle bacilli could be found in the expectoration, which microscopically gives the idea of pus rather than sputum.

W. H. D., PRESTON PARK.—A few tubercle bacilli are present in the sputum.

E .R. M., HASTINGS.—No tubercle bacilli could be found in the specimen.

J. M. O., FISHGUARD.—No tubercle bacilli could be found in the sputum.

A. R., LEWISHAM HILL.—The material is chiefly composed of mucus, in which are floating masses of degenerated pus. There are no hooklets or other characteristic elements, and the material does not give the reaction of bile.

A. C., SAXMUNDHAM.—Specimen F. The culture made shows a large quantity of small growth, which on microscopic examination is found to consist of staphylococci, streptococci, and short bacteria, but no bacillus diphtheriæ is seen.

A. C., SAXMUNDHAM.—Specimen H. The culture made shows a number of pin-point semi-translucent colonies not suggestive of diphtheria. Microscopic examination shows that the colonies consist of a mixed growth of cocci, but no bacillus diphtheriæ is observed.

B. C. G., STANMORE.—The exudation on examination does not show the presence of the bacillus diphtheriæ. The culture after twenty-four hours produces no growth suggesting diphtheria. On microscopic examination of the surface of the medium there are found numbers of streptococci but no bacillus diphtheriæ.

A. S., CHELSEA.—The culture at the end of twenty-four hours shows no growth distinctive of diphtheria. Microscopic examination proves that the growth present

consists mainly of streptococci. No bacillus diphtheriæ is observed.

J. W. O., Bideford.—The tumour of the breast is a carcinoma composed of large alveoli, filled with spheroidal epithelium. At the growing edge of the tumour the gland shows chronic induration and dilated ducts.

H. E. P., Loughborough.—The breast shows a typical scirrhus carcinoma with many secondary nodules diffused through the breast and along the sub-mammary lymphatics. The growth is not freely removed at the lower and inner quadrant of the organ. Nipple unaffected. Embedded in the breast is a small fibro-adenoma, and a few retention cysts are found in the atrophied part of the glandular substance.

S. W., Middlesborough.—The material consists of mucus casts several inches in length, composed of mucus and fibrin. In them are embedded altered cells from the mucous membrane. There are no muscular fibres attached to the casts, hence they do not consist of the mucous coat of the bowel. PATHOLOGIST.

Guy's Hospital Students' Club.

The ordinary General Meeting for the election of non-resident members of the Committee was held on 26th March, in the Anatomical Theatre, Mr. Durham in the chair. There were about 40 members present, and after sanctioning the alteration of a bye-law to the effect that no dinner be ordered after 8 p.m., the meeting proceeded to elect its representatives, with the result that Messrs. V. E. Collins, H. J. Spon, and H. T. Bell were chosen in order named. A hearty vote of thanks was accorded Messrs. Bryant, Clarke and Reynolds, the retiring Members of the Committee, for their services to the Club. Mr. Durham, who met with an enthusiastic reception, congratulated members on the condition of the Club, and commented on various incidental matters, concluding with a fervent expression of goodwill towards his hearers and Guy's students in general. Three hearty cheers were given for Mr. Durham, and the meeting separated.

Officers:

A. E. Durham, Esq., F.R.C.S., President.
C. J. Symonds, Esq., M.S., Hon. Treasurer.
J. Fawcett, Esq., M.D., Hon. Secretary.
H. J. Spon, Hon. Assistant Secretary.

Committee:

W. Hale White, Esq., M.D.	V. E. Collins.
J. W. Washbourn, Esq., M.D.	M. Hamblin Smith.
A. D. Fripp, Esq., M.S.	H. J. Spon.
H. T. Bell.	M. H. Thornely.

The President of the Resident Staff.

Sub-Committees.

Catering: V. E. Collins, M. Hamblin Smith, and the Hon. Secretary.

Newspaper: J. W. Washbourn, Esq., M.D., H. T. Bell, and M. H. Thornely.

Representatives.

On Gymnasium Committee: M. H. Thornely and the Hon. Assistant Secretary.

On Council of Clubs' Union: H. T. Bell and V. E. Collins.

Sport.

Cricket.

Officers for 1895.

President: A. E. Durham, Esq., F.R.C.S. Captain: F. J. Nicholls. Vice-Captain: A. Perks. Hon. Treasurer and Sec.: K. B. Alexander. Captain and Hon Sec. 2nd XI.: C. Anderson. Vice-Captain: T. Morgan. Committee: W. I. Hancock, R. T. Fitz-Hugh, P. C. Prince, and C. A. Trouncer.

LIST OF MATCHES.

First Eleven.

May 4.—Beckenham ..... Beckenham.
„ 8.—Past and Present ..... Honor Oak Park.
„ 11.—Surbiton ..... Surbiton.
„ 15.—Hornsey ..... Hornsey.
„ 18.—Crystal Palace ..... Crystal Palace.
„ 22.—Dunstable Grammar School ... Dunstable.
„ 25.—Mitcham ..... Mitcham.
„ 29.—Ealing ..... Ealing.
June 1.—Hornsey ..... Honor Oak Park.
„ 8.—Bickley Park ..... Bickley Park.
„ 12.—Brentwood ..... Brentwood.
„ 15.—Eastbourne ..... Eastbourne.
„ 18.—Croydon ..... Croydon.
„ 22.—Mitcham ..... Honor Oak Park.
„ 29.—Chelmsford ..... Chelmsford.
July 6.—Streatham ..... Honor Oak Park.
„ 13.—Brentwood ..... Honor Oak Park.

Long Vacation Eleven.

Aug. 3.—Streatham ..... Streatham.

Second Eleven.

May 4.—Granville II. ..... Lee.
„ 11.—Croydon II. ..... Honor Oak Park.
„ 15.—London Hospital A. ..... Honor Oak Park.
„ 18.—Pleydell ..... Honor Oak Park.
„ 25.—St. Thomas's Hospital II. ..... Honor Oak Park.
„ 29.—Pleydell ..... Honor Oak Park.
June 1.—Colonials ..... Honor Oak Park.
„ 5.—St. Bart's. Hospital II. ..... Honor Oak Park.
„ 8.—Upper Clapton ..... Upper Clapton.
„ 12.—Dulwich College II. ..... Dulwich.
„ 15.—Whitgift Wanderers II. ..... Honor Oak Park.
„ 22.—Mr. Moore's XI. ..... Honor Oak Park.
„ 29.—St. Thomas's Hospital II. ..... Honor Oak Park.
July 6.—
„ 10.—St. Bart.'s Hospital II. ..... Winchmore Hill.
„ 17.—London Hospital A. ..... Edmonton.

Birth.

TRESIDDER.—On the 10th instant, at 51, Sherwood Street, Nottingham, the wife of William E. Tresidder, M.B., B.S. Lond., of a daughter.

Death.

PELLY.—On April 3rd, at Woodstock House, Lee, Kent, Surgeon-General Saville M. Pelly, C.B., late Bombay Army, aged 76.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Medical Office, Guy's Hospital.

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

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Guy's Hospital Gazette,

MAY 11, 1895.

Arthur Edward Durham.

But a short time ago, we were deeply sympathising with him in his own sad trouble in the loss which he felt so keenly—the death of his son, the pain of which, without question, did much to bring him thus early to his own. When Arthur Durham was among us, he was seldom spoken of save as "the Old Man," *the* old man *par excellence*; nor is there, after all, in a community like ours, anything that can show regard—aye, and respect too—better than the currency of such a familiar name;—love does not deal in formal titles. After his son's death, two years ago, it was said everywhere about the Hospital, "The Old Man is not the same." Mr. Durham did not, it is true, when mourning for his son, abate one jot of his kindliness, nor did his teaching lose its interest, nor even his humour its charm. All the qualities which led to his extraordinary popularity were still in evidence; but there was a difference felt by each and all of us, and felt with a subtle pang. A factor had gone from the sum total of things, a flavour was missing from our Guyite existence; it was because "the Old Man was not the same." Yet he was not old, save in our regard, and we might have hoped to enjoy his ever welcome visits to Guy's these many years to come—but now, it is *vale!*

Not much later than the loss of his son came his retirement from the active staff of Guy's, and this, we do not doubt—none could doubt who ever heard him speak of it—brought no little suffering of its own kind; and, by severing the bonds of many attachments, while it took him away from a pleasant and familiar routine, helped, perhaps, to undermine his health. Yet, when he came back from a voyage amid the Northern ice, and told us how he had played cricket by the light of the midnight sun, we forgot all this, and never dreamed but that he was hale and hearty once more. And that was but a few months since!

Some years ago an admirer of another revered Guy's teacher, then just dead, said to us, with a look of pity which we cannot even now forget: "Ah, but you never went round with Moxon!" That is how we cannot help feeling for those just now beginning their ward work. "Ah, but *you* never went round with Durham; *you* never heard one of the Old Man's clinicals." The influence of his personality went far outside the circle of his own house-surgeons and dressers; this we who write can testify, for we were never "of the Old Firm." Whilst many Guy's men are mighty surgeons in the land, because of his teaching and example, there are many more who have learnt how a life's work may be done with the gentleness and kindness, the unselfishness, and the consideration for others, which were so characteristic of the beloved teacher we have lost.

We do not attempt to say anything here of Mr. Durham's life and work. They will be dealt with later by an abler hand. This is but a foreword of unfeigned regret for our own great loss, and of deep sympathy with his family in their bereavement. If the regard of a thousand friends could lengthen a man's days, if respect and admiration could ward off for a season the sadness of death, Arthur Durham would assuredly be still among us.

The Summer Entry.

We hear on good authority that the Summer Entry has not, up to the time of writing, been a large one. This news will doubtless rejoice the hearts of those few students who appear to be under the impression that the Medical School at Guy's has become overcrowded. However such an impression, created without the shadow of foundation and disseminated with some success by a few discontented individuals, prevails at all is difficult to understand. We have taken the opportunity to make enquiries as to whether there is any substance in such rumours that have from time to time reached us. While it is a matter, perhaps, for congratulation that the number of our students has never been too excessive for them to receive adequate instruction and attention from the lecturers and demonstrators of the Medical School, we cannot help insisting upon the point that if our School is to keep its high position as a teaching centre, the chief means thereto is in maintaining a full entry, and this needs the hearty co-operation of all our students—past and present.

For it is unquestionable that the spirit of a large School such as Guy's has an effect on its teachers and demonstrators much the same that "full houses" have on the members of a theatrical company. It stimulates the professors on their part to put forth their best efforts to impart knowledge, and, by reason of an appreciative keenness among the students, promotes and cultivates a healthy desire for emulation, which, after all, is what its most ardent well-wishers consider of the first importance to *our* School.

Therefore, with every confidence, we can congratulate our new Students, Medical and Dental, on their choice of Guy's as their *alma mater*. We may remind them that, upon their becoming Students, new responsibilities and duties are theirs. They have firstly to use to the best of their ability the many opportunities which Guy's affords them, not only to make themselves competent, and, if they will, first-rate practitioners, but also to maintain the best traditions and the high reputation of the Medical or Dental School to which they have attached themselves. Not the least important of their duties also is to loyally support the Clubs' Union and its constituent institutions. There is a tendency to accept the privileges which such an amalgamation gives to Guy's men as a matter of course, on payment of the subscription; this is but the commencement of what should be a pleasurable duty. Active support is a necessity from every member of the Clubs' Union, and we hope that each will show his practical sympathy by participation during the ensuing session in cricket, lawn tennis, athletics, cycling or swimming, according as inclination and capabilities direct.

Hospital News.

In the Medical Wards.

Case under Dr. Goodhart.

J. D. H., æt. 42, a waterside labourer, admitted April 29th, 1895, for epistaxis, cough and dyspnœa. Patient is married, and for the last twenty years has been engaged in his present occupation, during the course of which he has been exposed to all kinds of weather. He has been a heavy drinker.

Previous medical history.—Eight or nine years ago he was an in-patient at the Newington Infirmary from lead colic, as the result of working in a lead factory. For the last ten or twelve years he has suffered from gout, the pain first coming on in the right big toe, then in the knees, and lastly in the elbows, wrists and finger-joints consecutively. Patient has some tophi in helix of right ear. Twenty-eight years ago was in the Liverpool Road Hospital with typhoid fever, and ten years ago he also had gonorrhœa.

History of present illness.—A week after Christmas, 1894, patient began to spit up blood and went to St. Bartholomew's as an out-patient, where he seemed to get a little better. The blood was of a dark colour at night, but in the morning it got much thinner and brighter. Patient has suffered a great deal from pains of a lancinating character in his heart. Patient's knees used to swell a great deal when he had pain in them, but it was not till about the 22nd of April that he noticed his left leg was more swollen than the right.

Condition on admission.—Face very anæmic. No blue line along gums or puffiness in the eyelids. The feet and legs are œdematous, the left worse than the right. There is fluctuation in the left knee-joint. There is no marked ascites of the abdomen. No thrill to be obtained. Liver very much enlarged, extending down to the level of the umbilicus.

Circulatory system.—Cardiac impulse is visible in the sixth left space, one inch outside the nipple line. Cardiac dulness limited to the fourth costal cartilage above, internally to the middle line of the sternum, and externally by about half a finger's breadth outside the nipple line. There is a loud, blowing, systolic murmur to be heard at the apex.

Respiratory system.—There is dulness behind over the right lung, extending up to the angle of the scapula, with deficient entry of air and crackling râles over the dull area. There are loud snoring rhonchi to be heard all over the chest.

Urinary system.—Acid in reaction. Sp. gr. 1009. No blood or pus. Albumin, 3 parts per 1000 (1·31 grs. per oz.). Urea, 1·5 parts per 1000 (6·56 grs. per oz.). Average quantity per diem during three days, 38 ozs.

This case shows very well the sequence of events following on lead poisoning, their order being (*a*) lead colic; (*b*) gout; (*c*) chronic interstitial nephritis; (*d*) bronchitis; (*e*) epistaxis.

The patient is himself also interesting in that he has a well-developed left mamma, the lobules of the gland being distinctly felt; the right mamma is normal.

CASES UNDER DR. HALE WHITE.

THREE CASES OF INTRA-CRANIAL TUMOUR—OPERATION FOR THE RELIEF OF PRESSURE—MARKED ALLEVIATION OF SYMPTOMS.

CASE 1.—W. J., æt. 9. Stephen 39. Admitted April 8th, 1895, for headache, vomiting, blindness, and ataxy.

Previous history good. No special illnesses. No family history of tubercle.

Present illness commenced about January 1st; patient was thought to have influenza; he has never been well since, but has suffered from headache and vomiting. About the same time his gait was noticed to be staggering, and he seemed to be stupid and drowsy—particularly when the headache was severe. His sight has been getting worse since last summer. There have been no fits.

On admission.—Nervous system.—Patient has a vacant expression; head large (22 inches circumference); broad at the back. Headache frontal, and vertical, occasionally occipital; nearly constant; worse at times. Pupils dilated. Well-marked nystagmus. Patient can see nothing with the right eye; with the left he can tell light from darkness. Right disc completely atrophied; left shows neuritis, with partial atrophy. No obvious loss of power or paralysis of muscles. Knee-jerks and plantar reflexes very deficient. Patient cannot stand or walk alone, but exhibits a tendency to fall backwards and to the left, or sometimes directly backwards. Vertigo is present. Sensation normal. Other systems normal.

Dr. Hale White, in going over the case, said that the diagnosis of intra-cranial tumour was certain from the three cardinal symptoms of headache, vomiting, and optic atrophy, while the nystagmus and deficient knee-jerks indicated its position in the cerebellum; and, further, that the tendency to fall backwards and to the left showed that tumour was in the posterior part of the middle lobe, and extended more to the left than to the right. With regard to its character, in the absence of other evidence of tubercle, it was probably a glioma. In consequence of the intensity of the headache and the progressive loss of sight, it was determined to trephine to relieve pressure.

Operation.—An area of bone ¾ inch in diameter was removed by Mr. Dunn from the left side of the head, 2½ inches behind the external auditory meatus. A circular piece of like size was also cut out of the dura mater. Immediately this was done the cerebellum was observed to bulge forward through the trephine hole, indicating the great intracranial pressure.

After the operation patient had no return of the headache, but he gradually sank. On the seventh day he developed Cheyne-Stokes' respiration, and hiccough, and on the ninth day he became comatose and died. Sight did not improve.

Post-mortem examination.—Brain very large, distended with about a pint of fluid. A soft gelatinous tumour, apparently a glioma, was found growing from the lower surface of the cerebellum. It involved the lower part of the middle lobe and extended on either side into the hemispheres, involving the left more than the right; below it was adherent to, but had not involved, the medulla. It measured 2½ inches antero-posteriorly; 2½ inches transversely, and 1 inch vertically. As a result of the tumour, all the cavities of the brain were much distended; the lateral ventricles measured 6½ inches in length and 1½ inches across at the narrowest part, while the skull was reduced to one-third of its normal thickness, and was marked by the convolutions.

CASE 2.—T. P., æt. 33. Stephen 34. Admitted March 8th, 1895, for headache, blindness, left-sided numbness and twitchings.

Previous history.—Injury to head 18 years ago from a fall—stunned for about 10 minutes. No family history of tubercle, etc. No venereal disease.

History of present illness.—Sight began to dim last July; patient attended Eye Out-patients. At Christmas, 1894, gnawing headache near right ear radiating over adjacent parts of skull; left leg was noticed to be weaker; headache prevented any but the most broken sleep.

On admission.—Pupils dilated equally and do not respond to light; no accommodation; all but blind; cannot see person at a foot's distance. *Opthalmoscope.* Both discs atrophied; right eye worse; left eye is very much weaker than right. Gait good. Knee-jerks and plantar reflexes absent on both sides. Unilateral left-sided sweating at night; no nystagmus. *Taste* normal. Various hallucinations of sense. Headache very severe and continuous—it prevents sleep altogether, and heat and cold perceptions normal on both sides. Headache persisted, if anything, increasing in severity.

On April 4th Mr. Dunn operated, with the same object as in last case; after the trephine had been used and bone plate removed, a triangular slip of dura mater was excised; wound sewn up and dressed. Highest temperature 99·8 after operation.

5th. Patient feels sick this morning; has slept well during the night, and has no pain in head.

8th. Patient maintains his sight improved; no headache whatever.

13th. Wound dressed to-day; united completely. Patient has had absolutely no headache since operation.

20th. No headache. Patient says he can distinguish persons—at any rate his sight is improved to the degree that he can pilot himself about the ward.

27th. No headache at all. With the slightest assistance patient can take exercise for an hour or so in the park. Sight still improving.

Case 3.—M. A. R., æt. 19. Mary 9. Admitted April 18th, 1895, for cephalalgia. Patient was first admitted in 1892, for vomiting, headache and blindness. Re-admitted January 10th, 1893, and on August 11th, and April 23rd, 1894; always for headache, pain being on top and back of head. Hand grasps weak. No localising symptoms. Variable areas of anæsthesia during the several admissions.

August 31st, 1894. Patient was operated on for the intense headache. A plate of bone removed by Mr. Lane, and an exploratory puncture made into dura mater about 2·5 inches above ear. Dura mater was not opened by reason of the great brain tension apparent. Bone replaced.

December 20th. Re-admitted into Miriam. Same symptoms except headache, which has not returned since operation in autumn.

29th.—Headache returned with all its own severity; continued up to January 15th. Mr. Lane operated on the site of the former incision. Triangular plate of bone removed, dura mater incised and a slip removed. Headache relieved at once and sight markedly improved, although the discs appeared atrophied. Discharged relieved February 10th.

History since discharge.—After a month's freedom, pains returned all over the head, except forehead; anæsthetic areas; variable unilateral deviation of tongue. Blindness, which has become worse again, is to the degree of counting fingers at a foot. Headache intense and agonising; no time relation to meals; prevented any adequate sleep; lasted equally through twenty-four hours.

23rd. *Operation.*—Mr. Lane removed a plate on the old lines, and then removed two parallel strips of dura mater.

24th. No headache; sleeps well.

26th. No headache; sleeps well.

30th. No headache; sleeps well. Her sight is so improved that she can count fingers.

May 1st. Wound dressed; complete union. Patient finds her way about ward by sight.

Cases under Dr. Perry in Clinical Wards.

Acute Lobar Pneumonia—Ulcerative Endocarditis (Tricuspid)—Suppurative Meningitis—Death—(Bronchiectasis—Hydatid of Liver).

John 6.—Edwin W., æt. 58, butcher. Admitted April 27th, 1895, for weakness and fever of a month's duration.

Family history.—Patient has a son and daughter living. The daughter was in Miriam twelve months ago for hydatid of liver. It was opened and drained, and patient went out well.

Previous history.—Patient has lived in London all his life, and has for forty years worked as butcher.

Previous medical history.—He has been a perfectly healthy man, except for occasional coughs, and has not had to lie up on any previous occasion. He is a moderate drinker. No history of venereal trouble or rheumatic fever.

History of present illness.—About a month ago patient was taken with what he calls a "violent cold." The onset was not distinct; there were no rigors; in fact, patient was unwell for two days before giving up work. He was then obliged to take to his bed, and has remained there till his admission. About a fortnight ago a doctor was called in. He diagnosed "inflammation of the lungs." At the beginning of the illness patient had diarrhœa; but for the last week or so he has had constipation. During the last fortnight cough has been troublesome, with, however, very little expectoration. Throughout the illness patient has been much troubled with dryness and foulness of tongue and mouth. He has been feverish, but not delirious.

Patent has taken nothing but fluids during the illness. He has got much thinner.

Condition on admission.—Temperature 99·8; pulse 120; respiration 40. Patient is a spare man, obviously very ill. He is wasted, and is hardly able to move in bed.

Respiratory system.—Breathing is rapid and shallow. Cough is only occasional and is dry in character. Chest is long and narrow, but with wide epigastric angle. Left chest moves better than right. There is dulness at right base behind, up as far as the inferior angle of scapula. The dulness is not absolute. Over the dull area breath-sounds are diminished, but distant bronchial breathing is heard. There is also bronchophony and pectoriloquy at right base, and fine crepitating râles during inspiration. Occasional rhonchi audible all over chest. At the left base the breath-sounds are exaggerated, as in fact they are, but in a less marked degree, over whole of left lung.

Alimentary system.—Abdomen is not distended, and moves well with respiration. There are no rose spots; no tenderness on palpation.

The *spleen* can be felt on deep inspiration below costal margin.

Liver dulness normal. Edge cannot be felt.

Tongue dry, covered with brownish fur. Appetite poor. Bowels have not been opened for two days.

Circulatory system.—Apex beat cannot be seen or felt. Cardiac dulness diminished. Heart-sounds feeble, but otherwise normal. Pulse 120, soft, full, regular.

Urine.—Sp. gr. 1015; acid; albumin ·25 parts per 1000; no sugar or blood.

Treatment.—Milk and soda water; Brandy, ʒiii.

Liq. Strychn. Hydrochlor., ♏v.
Caffeine Cit., gr. v.
Glycer., ʒi.
Aq. Chloroformi, ad ʒi. 4tis horis.

At 10 p.m. patient's temperature fell to 97, and he was found to have cold extremities, and to be much

collapsed. An ounce of brandy was given, and patient quickly revived.

April 28th. This morning urine contained no albumin, and did not give Ehrlich's reaction. Yesterday bowels were open twice, but motions were dark and well-formed. This afternoon Dr. Perry discussed the diagnosis. Typhoid fever with hypostatic congestion or pneumonia, with delayed resolution, seemed most probable. In the evening the temperature rose to 104 at 6 p.m., with corresponding rise in pulse and respiration.

29th. The morning temperature was 97·2; the evening 104; patient's condition being much as on previous day.

30th. The physical signs at right base are much as on admission, but have extended up to the spine of scapula. A needle put in the eighth space only withdrew a few drops of blood. Bowels were opened twice, motions presented nothing peculiar. The possibility of typhoid fever was abandoned, and "pyæmia" seemed the most probable diagnosis. The source of the infection was not obvious however. Patient's brandy was increased to six ounces, and egg and milk, custard, and beef-tea ordered. Temperature 97 at 10 in the morning.

May 1st. Temperature rose to 102·8 at 2 a.m., and was lowest at 6 p.m., being then 97·4.

2nd. Temperature at 2 a.m. 104; at 6 p.m. 98·2. Patient was much collapsed when the temperature reached 104. An ounce of Mist. Ammon. et Etheris and an ounce of brandy were given, and ordered to be repeated when temperature rose. The bronchitis is increasing, so that heart-sounds cannot be heard.

3rd. Temperature 103·4 at 2 a.m., and remained above 102 till 6 p.m., when it fell to 101. Patient remained in a collapsed condition throughout the day, sweating profusely and passing urine and fæces into the bed. Pulse could not be counted at wrist. Patient remained in the same condition till his death at 9 a.m. on May 4th.

Post-mortem.—Lungs.—Thickened pleura over both bases behind.

Right.—Whole of lower lobe solid, presenting red and grey hepatisation. Quantity of muco-pus in the smaller tubes.

Left.—There was a cavity, about 2 inches by 1 inch, communicating with left bronchus, containing pus. Rest of this lung normal; no consolidation.

Heart ʒx. Fungating mass of recent vegetations on all cusps of tricuspid valve. Aortic, pulmonary, and mitral valves healthy.

Spleen ʒx. Dark coloured.

Kidneys ʒxiii. Showed a few petechiæ on surface.

Brain.—Pus in the meshes of the piamater over surface of both hemispheres, and also on posterior and inferior surfaces of cerebellum.

Liver ʒlxii. Adherent to diaphragm at upper and posterior part of right lobe. A hydatid cyst, about the size of a large orange, containing many daughter cysts, was embedded in the liver at this part, so as to project only slightly beyond the general hepatic surface.

Intestines, bladder and testis normal.

A cultivation was made from the pus beneath the meninges and the Talamon-Fraenkels pneumococcus was found.

The case, therefore, appears to have the following sequence of events:—Acute lobar pneumonia; ulcerative endocarditis (tricuspid); suppurative meningitis. Hydatid of liver and bronchiectasis being, so to speak, accidental conditions.

Elizabeth A., æt. 13 years, a schoolgirl, was admitted for cough with fœtid expectoration. There is a strong tuberculous family history.

Her previous history is important. Six years ago she was in the Hospital, under Dr. Taylor, for diphtheria. Tracheotomy was performed, but some lung trouble developed, there being signs of consolidation at the right base, due to either pneumonia or collapse. The report says that all abnormal physical signs cleared up, and she left the Hospital quite well.

The history after this is that she has always had a cough, and that two years ago, during an attack of erysipelas of the face, the cough became worse, and she brought up a large quantity (? a pint) of thick yellow matter from the lungs all at once. Since then she has been fairly well, but at intervals of three to six weeks she has brought up a large quantity of the same kind of stuff from her lungs, and her breath has been foul. She has never brought up any blood.

Four days before admission she brought up a large quantity twice, and has been feverish and complained of headache since.

Condition on admission.—Temperature 104; pulse 108; respiration 28. She did not look very ill; there was no dyspnœa and no pain. Her cheeks were red, and dilated venules visible, having rather the appearance of chronic venous congestion. The chest was symmetrical, but the right side did not move as well as left. There was dulness below the right scapula, diminished breath-sounds over the dull area, and some crepitations in right infra-mammary region. The left side has always been normal. The heart's impulse could be felt to right of sternum, and in epigastric angle the sounds were normal; alimentary and nervous systems normal.

Progress.—The temperature fell gradually, and was normal in four days. The chief complaint was headache for two days. For a few days there were râles over whole of right side, consonating in character; these cleared up. The dulness has been practically unchanged below the nipple in front and angle of scapula behind. The other physical signs vary a great deal. Tubular breathing over the inner part of the dull area behind is constant. At times there is marked broncophony and pectoriloquy over the same part, but five minutes later there may be no broncophony at all, or, if the broncophony is absent, after getting her to cough, one finds it present. No bruit d'airain.

Since coming in, she has only brought up a small quantity of purulent sputum, in which the tubercle bacillus could not be found.

She has now been in three weeks, and is quite well, but for shortness of breath on much exertion, occasional cough with foul breath, and the signs of cavity at the right base.

Dr. Perry thinks that she had pneumonia when admitted; and that she has bronchiectasis, having origin probably in the pneumonia six years ago: this would make the lung all the more liable to a fresh attack. For the first few days the idea was entertained of an empyema which had opened into the lung and was discharging through it. This and a bronchiectatic cavity would cause the same results, and they would be difficult to distinguish, both clinically and pathologically; a large cavity with a bronchus opening into it would exist in each case. The cavity would take some time to fill up and then the contents be discharged. The lung in either case would be fibroid, and this accounts for heart being pulled over to the right.

Phthisical cavity at the base has been suggested; but the patient is fairly fat and not at all anæmic.

The treatment has been chiefly nursing and feeding. She appears quite well, and there is no rise of temperature at all, so that Dr. Perry has not put in a needle. Iodoform pills are being tried for the foul breath, and she is going out in a few days.

Caroline, A. E., æt. 22, unmarried. Admitted a month ago with what was thought to be acute rheumatism. A year ago she was laid up for three weeks with swollen and painful ankles and feet; but there is no other history of rheumatism. A fortnight before admission she had swelling and pain in right foot; afterwards wrist and fingers, then left foot and hip, and finally right foot again became swollen. Feverishness was only noticed the day before admission; profuse sweating throughout.

On admission.—She walked in. Temperature 104; pulse 156; respiration 24. There was tenderness of ankles and dorsum of feet and of right calf. There was practically nothing else abnormal; and the temperature throughout has been the most prominent physical sign. Being regarded as an acute rheumatism with no complications, she was put on milk and salicylate of sodium; and the next morning the temperature was normal and she was more comfortable. But in the evening the temperature was 104, and ten hours later again below normal, while all pain and tenderness had gone.

After four days she got symptoms of salicylism; sodium bromide (gr.x.) combined with the salicylate relieved them a good deal; but after trying antipyrin it was found necessary to omit the sodium salicylate. The temperature had an evening rise to about 101 till the end of the first week; then it was continuously up, between 100 and 102 for four days; then for eleven days it was somewhat irregular, between 98 and 102·5, generally higher in evening; sometimes not reaching normal during the twenty-four hours; for a week it has been about 98 to 99 in morning, and 102 to 104 in evening.

The pains have returned as soon as the salicylate has been taken off, but she stands these so badly, that it has been necessary to omit them. The temperature is hardly at all influenced. Quinine salicylate has been tried, also alkalies, and now sodium salicylate with methyl acetanilide. The cardiac physical signs have remained normal.

On May 6th there was a distinct circumscribed tender red swelling on dorsum of right foot, and Dr. Perry explored it for pus, but none was found.

8th. The swelling on foot has gone down considerably, but the temperature is still up. She is much paler than on admission, but her general condition is very good.

At first she was thought to have simple acute rheumatism, but on that supposition it is difficult to explain the continued pyrexia. The character of the pyrexia has suggested ulcerative endocarditis, but there is no physical sign at all pointing to endocarditis or emboli; and, further, patient seems fairly well. Leucorrhœal synovitis has been suggested, but she has no vaginal discharge, and the temperature is high for that. Acute rheumatism is all one can be certain about.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	1.	Cleft palate.
	6.	Old fracture of tibia. Inversion of foot.
Charity	8.	Incarcerated femoral hernia. Kelotomy.
	12.	Bronchocele.
	13.	Irreducible umbilical hernia.

Cases under Mr. Davies-Colley.

Lydia	5.	Double hare-lip.
	15.	Pedunculated fibroma dependent from vulva.
	19.	Pedunculated lipoma from buttock.
	Cot.	Cleft palate and hare-lip.
	Cot.	Ankylosis of hip-joint following suppurative arthritis, occurring as a sequela to scarlet fever.
Luke	14.	Carcinoma recti. Excision by lateral incision through ischio-rectal fossa, leaving sphincter ani intact.

Cases under Mr. Lucas.

Lydia	11.	Carcinoma recti.
	14.	Umbilical hernia.
	Cot.	Spinal caries. Dorsal abscess.
Job	3.	Encysted hydrocele of cord.
	4.	Tubercular abscess of chest-wall. Excision of knee last year for tubercular disease. Man aged 51.
	17.	Varicocele.
	18.	Hæmaturia.

Charity	3.	Swelling of elbow, following attack of influenza.
	4.	Carcinoma recti.
	Oct.	Congenital webbing of fingers.

Cases under Mr. Golding-Bird.

Cornelius	3.	Colles' fracture. Synovitis of knee. Fractured femur.
	19.	Fractured humerus. Fractured fibula.
Martha	2.	Swelling lower end of femur. Exploration: doubtful whether sarcomatous or inflammatory.
	4.	Pulpy knee.
	8.	Early hip-disease.
Lazarus	5.	Severe hæmorrhage from naso-pharynx.
	19.	Ankylosis of knee in flexed position, following on an acute arthritis of doubtful nature.
	22.	Abscess in head of tibia. Opened last year.

Case under Mr. Jacobson.

Naaman	22.	Chronic superficial glossitis (icthyosis). Epithelioma. Excision of tongue.

Cases under Mr. Lane.

Job	14.	Glandular mass in groin. Simulating femoral omental hernia.
	15.	Ankylosis of hip.
	15.	Displacement of internal semilunar cartilage.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Guy's Nurses' Lawn Tennis Club.

Dear Sir,—As you have been good enough to criticise favourably the scheme of the Nurses' Lawn Tennis Club, perhaps you would allow me a short space for a few remarks about it.

The Terrace and Tennis Courts thereon at Honor Oak Park have been set aside for the exclusive use of the Nursing Staff on three mornings of the week, namely, Monday, Thursday, and Friday; but the new Courts at the entrance of the ground will be open for the use of members during these times.

The success of the undertaking, and the enjoyment of the Nurses is in great measure dependent on the absence of spectators, so we would earnestly request all members of the various clubs to use the far end of the ground as little as possible during such times as have been allotted for the benefit of our able Nursing Staff.—Yours truly,

ASTLEY V. CLARKE
(Capt. Guy's Hospital L. T. C.).

Sir,—We have much pleasure in forwarding the names of the Members of Guy's Nurses' Tennis Club, also a card of general information. May we take this opportunity, through the medium of the Gazette, of thanking those gentlemen who have so kindly lent the Courts for our use, and assure them how fully we appreciate the general interest which has been shown? We spent a most enjoyable time on Monday, when we had our first practice, and are looking forward to many more happy mornings at Honor Oak Park. Yours truly,

THE MEMBERS.

Rochester Diocesan Society.

Dear Sir,—Next Sunday, May 12th, the cause of the Rochester Diocesan Society will be pleaded in our chapel, and offertories will be gathered for the same. The morning preacher will be the Rev. S. F. Hooper, Vicar of Holy Trinity, Blackheath Hill. In the evening the preacher will be the Rev. F. S. Ranker, of S. Augustine's, South Bermondsey. The offertory for this Society from Guy's has hitherto been one of the largest from this neighbourhood. Probably one reason for this result has been that we, who see so many of the evil consequences of evil living, cannot but value very highly any agency which seeks to improve the moral and spiritual welfare of this neighbourhood, and, foremost amongst these agencies, stands the Rochester Diocesan Society. I trust that our chapel contribution this year will not fall below the level of those of previous years, and I shall be glad to add thereto any subscription, great or small, which may be sent to me by those unable to attend on Sunday.—I am, dear Sir, yours faithfully,

C. H. BOWDEN, Chaplain.

Notes from the Dispensary.

Physic Nuts.—On Wednesday, April 24th, a number of children were treated in the front surgery for symptoms of poisoning, which consisted of vomiting, with a slight amount of depression and collapse. They had eaten some seeds picked up in Sparrick's Row and which they described as cocoanut beans. The seeds were those of a euphorbiaceous plant, the Jatropha purgans (Curcas purgans), and are called Physic Nuts. They yield by pressure about 30 per cent. of fixed oil, and both seeds and oil are drastic cathartics. The Jatropha purgans oil is commonly distinguished as Oil of Wild Castor Seeds, and it is said that it is used for adulterating East Indian Croton Oil. This oil is official in the Pharmacopœia of India. It has a bland almond-like taste, and 12 to 15 drops are equal to one ounce of castor oil. Applied externally, the oil has a stimulant effect. In India it is used as a local application fo increasing the secretion of milk. The seed is largely exported from the Cape de Verd Islands to Portugal, where the oil is extracted, and used principally for

burning, under the name of purguivera oil. In English commerce it is known as Pulza Oil, or Seed Oil.

FERROPYRINE.—The newest remedy at Guy's is Ferropyrine. This substance is composed of one molecule of Ferric Chloride and three molecules of Antipyrine. It is a yellowish powder soluble in 5 parts of water at 15° C., but it requires 9 parts in order to dissolve it at 100° C.; thus it happens that a watery solution saturated in the cold precipitates on boiling. The solution has a bright red colour. Ferropyrine appears to combine the properties of Antipyrine and Ferric Chloride without its caustic properties. It has been given in doses of 5 grains for chlorosis.

TO DETECT THE BACILLUS OF TYPHOID FEVER.—The following method is given by Syonnet in *La Semaine Médicale*:—Decolorise an ordinary bouillon with animal black, add carbolic acid 1 per cent., milk sugar 20 per cent., and small quantity of Congo Red. If the bouillon remains clear no typhoid nor the coli bacillus is present. If the typhoid bacillus be present the milk sugar does not ferment; the bouillon becomes cloudy, but remains red. The fermentation of lactose produces lactic acid, which changes the bouillon from red to violet.

MYDRINE.—In Merk's Market Report is given an account of a new pupil-dilator, termed Mydrine. It is a white powder soluble in water and composed of two mydriatic alkaloids, Ephedrine and Homatrophine. In rapidity of action and the short duration of the dilation produced it is much superior to Homatrophine. Ephedrine is an alkaloid obtained from the leaves of Ephedra Vulgaris, a plant belonging to the family Guetaceæ. The following is the formula of the Mydrine Solution:—

Mydrine	0·30	gramme.
Aq. Distil.	3·00	"

H. COLLIER.

A Case of Lobar Pneumonia with Hyperpyrexia.

THE following case may prove of interest:—

J. W., æt. 44, head gardener, a temperate, fairly robust, but excitable man, was seized with intense pain in the left side and difficulty in breathing on April 11th. He continued his work till the 13th, when I was called in to see him. He was delirious, and refused to stay in bed. Temperature 103; respiration 36; pulse 115. He had well-marked consolidation of the left lower lobe, with herpes labialis and a hot and dry skin; sputum scanty and blood-stained, but not rusty. The usual drugs and brandy ʒiv. were ordered, and a morphia injection given.

On the 16th he was still delirious. Temperature 100; respiration 40; pulse 120; but during the evening temperature rose to 105. The left lung was entirely pneumonic, and further pneumonia was found at the right base behind. He had excessive diarrhœa.

On the 18th, temperature at 8 a.m. was 101; respiration 40; pulse 125; and during the day temperature rose steadily to 10 p.m., when it reached 108·4, and I found that the pneumonia had increased very considerably on the right side, and he was violent and delirious.

On the 19th, at 7 a.m., temperature was 106·2, and at 11 a.m. it rose again to 108.

He died at 12 midday, April 19th.

Malpas, Cheshire. H. A. DUFFETT.

Examination Papers.

University of Cambridge.

SANITARY SCIENCE EXAMINATION FOR D.P.H.

TUESDAY, APRIL 2ND, 1895. 9—12.

PART I. PAPER 1.—1. State the precautions to be adopted in placing and reading maximum and minimum thermometers when it is desired to register outdoor temperatures of the air. Give reasons for adopting those precautions. 2. How and by what means is nitrification effected in the soil, and what are the conditions essential for its continuance? What are the factors requisite for the production of (*a*) nitrites, (*b*) nitrates in the soil? 3. What are the respective advantages, disadvantages, and dangers, if any, attendant upon the use for warming rooms of (*a*) open firegrates, (*b*) slow combustion stoves, (*c*) closed coke stoves, and (*d*) gas stoves? How may these disadvantages and dangers be best overcome? 4. What are the constituents, and the variations in the proportions of these, in cow's milk, and in fresh butter; and in what respect does the latter differ chemically and physically from margarine? 5. How would you make a physical examination of a drinking water to determine its colour, clearness, lustre, odour, taste and sediment? What substances, and what amounts of these, are likely to give a water an objectionable taste? 6. State the normal proportions—by weight and by volume—of the constituents of the atmosphere, and how, and to what extent they are affected by contact with water and with the soil respectively. To what extent may the oxygen in an atmosphere be diminished without imperilling human life?

WEDNESDAY, APRIL 3RD, 1895. 9—12.

PART I. PAPER 2.—1. Explain the law of Montgolfier and apply it to the following case:—Height of throat to top of chimney 20 feet. Temperature inside 69° Fahr., outside 47° Fahr. Sectional area of chimney-throat 1 square foot. Further, if the total space of the room be 10,000 cubic feet and four men occupy it for three hours, what amount of CO_2 per 1000 cubic feet of air will be present in the air of the room at the end of that time? 2. A sample of water is suspected of being the cause of an outbreak of enteric fever. Explain in detail how you would make a bacteriological examination of the water for the micro-organism usually associated with this fever, and state the methods you would adopt for differentiating it from any other likely to be mistaken

for it. 3. What are Carbohydrates? State their general chemical composition. What are their uses in the body? 4. What are isobars? What forms do they assume? Explain the chief types of weather usually associated with each of these isobaric arrangements. 5. Explain the best method of constructing house-drains in relation to the house itself and to the sewers or cesspools into which they empty. Illustrate your answer by sketches, in respect of (1) a detached house, (2) a house in a terrace. 6. A town had, in 1881, a population of 35626, and in 1891 one of 38754; it is required to know what its estimated population will be in June, 1895. N.B.—It is expected that this calculation will be made by means of logarithms; a table of logarithms being placed at your disposal.

THURSDAY, APRIL 4TH, 1895. 9—12.

PART II. PAPER 1.—1. Give an account of the legislation at present in force with regard to bakehouses. Explain how far it suffices to prevent baking from becoming an unhealthy occupation, and to secure the wholesomeness of bakehouses. If the present control is, in your opinion, insufficient, state in what respects it needs to be made more stringent. 2. What are the various points which urban district councils can deal with, under bye-laws, with a view of securing:—(*a*) sufficiency of space about buildings; (*b*) the ventilation of buildings; (*c*) the ventilation of rooms? In each case quote the statute under which the bye-law dealing with each point can be made. 3. What are the duties and powers of district councils and of medical officers of health, in the matter of securing the wholesomeness of milk-supplies? 4. What value attaches to the filtration of potable water:—(*a*) when carried out in bulk prior to delivery of the water into the mains; (*b*) when carried out by means of domestic filters? In both cases state the methods by which efficiency in filtration is most likely to be attained. 5. What are the conditions which tend to the production of post-vaccinal erysipelas? Specify the Instructions to Public Vaccinators which aim at avoiding such a result. Add, separately, any additional precautions which you may deem desirable whenever there is special risk of erysipelas. 6. State briefly the principal lines of action which should be recommended by a medical officer of health on the occurrence in his district of an outbreak (*a*) of enteric fever, (*b*) of relapsing fever.

FRIDAY, APRIL 18TH, 1895. 9—12.

PART II. PAPER 2.—1. Discuss the "antidote" theory of immunity from certain microbic diseases, and point out how far it accounts for the facts observed in the history of these diseases. 2. Point out the conditions leading to an excessive mortality amongst children under five years of age. 3. What influence has the establishment of drainage and good water-supply exerted upon the rates of mortality from different classes of disease? 4. Describe the symptoms, and state the chief predisposing causes of Scurvy. 5. To what diseases are workpeople especially liable, who are exposed to great heat, as in Iron-puddling, Glass-blowing, Baking? 6. How far does Alcoholic Intemperance affect the rates of mortality? Describe its action upon the course of disease, and the healing of injuries.

TUESDAY, APRIL 2ND, 1895. 2—5.

PRACTICAL CHEMISTRY.—(N.B.—Describe in each case the operations you perform as well as the results obtained.)—1. Make an examination of the sample of Water marked A or B and write your opinion as to its fitness for domestic use, giving reasons. (State the letter on the bottle.)

A, contained a fair amount of saline and albuminoid Ammonia, Chlorine, Nitrates, Nitrites and Lead.

2. Examine the samples of Air marked 1, 2, and 3, and state what, if any, gaseous impurities they contain.

These were (1) Sulphur Dioxide. (2) Hydrochloric Acid. (3) Carbon Dioxide.

WEDNESDAY, APRIL 3RD, 1895. 2—5.

PRACTICAL MICROSCOPY.—1. Examine the substance in the tube marked A, and describe (with sketches) the objects you find.

A, contained silk, cotton and linen fibres, potato and arrowroot starches, and human and guinea-pig hairs. Bacilli probably subtilis.

2. Examine the powder in the packet marked B, and state what it contains, giving the number of the packet.

B, contained arrowroot and potato starches.

3. Describe briefly the objects 1, 2, 3, 4, 5, and 6, and state what they are. (1) Puccinia graminis. (2) Ergot (head of). (3) Tænia solium. (4) Trichina Spiralis. (5) Smut. (6) Penicillium glaucum.

THURSDAY, APRIL 4TH, 1895. 2—5.

PRACTICAL EXAMINATION—BACTERIOLOGY.—1. Name the specimens under microscopes 1 to 5.

These were Cholera, Typhoid, Anthrax, Tubercle, and Diphtheria.

2. Identify the cultures labelled 1 to 5.

These were Cholera, Typhoid, Coli Communis, Diphtheria, and Subtilis.

3. Prepare a cover-glass specimen of a guinea-pig's spleen and stain it by Gram's method.

The specimen showed Anthrax Bacilli.

Viva Voce Examination.

FIRST CANDIDATE.

PART I.

1. What is the difference between bull's, cow's, and bullock's beef? What are the characters of good beef?

2. Difference between horse's and cow's beef, and how can it be made out with reference to characters of fat?

3. How can strength of tea be estimated?

4. Which is the best filter, and how does the charcoal filter become dangerous? Describe the chemical reaction that takes place in it.

PART II.

5. What is the influence of back-to-back houses on public health?

6. What trades increase mortality from public health?

7. Describe the influence of subsoil drainage on public health.

8. What are the obnoxious trades, and how do they influence health?

9. What is the cause of epidemic pneumonia? What is the morphology of the pathogenic organism?

SECOND CANDIDATE.

PART I.

1. What is the percentage of solids in milk?

2. How do you estimate quantitatively such solids?

3. How do you estimate quantitatively the lactein in milk?

4. Have you done much milk analysis? (this question was the inevitable corollary to the candidate's answers to the foregoing questions.) What was the general character and scope of your analysis?

5. Why does an old woman go out and buy a ha'porth of milk? (N.B.—This was not a conundrum as one candidate suggested, but as the milk was presumably to add to her infusion of Bohea, the question was intended to lead to a discussion on tea in general and the comparison of the strength of infusions in particular.)

6. How would you dry earth, for use in earth closets? (Not by means of a furnace, as this would destroy the nitrifying organisms.)

7. How would you proceed to demonstrate bacteriologically the presence of the bacillus typhi abdominalis in a given specimen of water?

8. How would you cultivate the cholera bacillus from a fatal case in man?

9. From what part of the intestinal canal would you collect the *materies morbi*.

Examiner here became tired of asking questions.

PART II.

1. What is your name? Who gave you——

2. What diseases are influenced by telluric conditions?

3. What is the relation between goître and soil?

4. How do you explain the connection between the level of the subsoil water and typhoid?

5. Do you know of any district in which improved subsoil drainage has been followed by decrease in the death rate from phthisis.

6. In the event of being called upon to advise the local sanitary authority in respect to plans submitted to them for houses to be built in a new street, to what points would you particularly direct attention?

7. What is the substance of the model bye-laws relating to this subject?

8. Have you read Dr. Buchanan's recent work on the relation between "back-to-back" houses and tubercular diseases?

PRACTICAL OUT-DOOR SANITATION.

Candidate was directed to examine and report upon "Mason's Court"—a small alley consisting of two-roomed houses on the right-hand facing a row of dilapidated hand-flushed long-hopper water-closets, which could have given points and a beating to a large majority of the Bermondsey slums. Friday evening was partly devoted by candidate to the study of the habits and life-history of the various members of the order Aphaneptera collected during the sanitary investigation.

A Physiological Relic.

THE following from a set of answers to an examination in physiology must have been excavated during some recent building operations. We give some extracts—they may be of interest to students of ancient physiological research.

In answer to a question which was presumably on the digestive functions, we learn that—

"Commencing with the stomach, there is a secretion of an acid nature. Its chief constituents are hydrochloric acid ·2, lactic acid, salts, and a principal digestive matter called pepsin. Albuminous food is converted by the acid of HCl. and pepsin into hemipeptones and antipeptones, from there it is conveyed into the liver by means of an asmosis or dialysis, there it is acted upon by the bile. This secretion is of a yellowish brown tint, and alkaline in reaction. The colouring matters are of two kinds, *Bilirubin* and *Biliverdin*, in man biliverdin is predominating. Other constituencies are salts, especially sodium salts, and two ferments: trypsin and renin. Bile converts albuminous matters into glycosides, and these are converted into anti and hemipeptones. Bile does not possess the power of changing hemi and antipeptones further on. From there the digested food is brought into contact with the pancreas by the small intestines. The pancreatic juice is an entirely alkaline secretion and acts best as such. Its chief constituencies are: *Mucin, Taurin, and Salts*" (the italics are ours).

"Its chief action is the further changing of hemi and antipeptones into peptones; from these they get absorbed into the system by the capillaries of the blood-vessels, and distributed by the blood to the whole body. Undigested matters undergo further change by the passage through the larger intestines, and lastly the nonabsorbed and undigested matters collect in the rectum and are expelled as such by the anus."

Another extract and we have done. This is the candidate's idea of the circulation: "A stream of blood enters the pulmonary artery into the left auricle and extending it by rhythmical contraction of the muscles, it contracts and expelles its contents into the left ventricle, where the first sound or *Pulse* is formed. From there the blood leaves the left ventricle through the pulmonary veins, passes through the capillaries into the vena cava, dilating the right auricle, making . . . ." And here age has stepped in to obliterate what follows. Truly, a little knowledge *is* a dangerous thing!

Passim.

A full obituary notice of Mr. Durham will appear in our next issue. We intend also to reprint a limited number of copies of his photograph, which was issued with the Gazette a year ago, in order that our more recent subscribers may also secure a copy. Applications for these must be made at once to the Librarian, who has instructions as to their distribution.

Mr. Durham had frequently suffered from bronchitis, and three years ago was found by a medical friend to be suffering from emphysema with dilatation of the right side of the heart. He had been failing in health since Christmas, but was out and about on the 4th and 5th of May, though feeling ill. On the evening of the latter day he was taken ill, and in a few hours the symptoms and signs of pneumonia appeared and proved fatal in not much more than twenty-four hours.

Those of us whom duty forbade to go westward yesterday were glad to have an opportunity of testifying to our respect for the late Mr. Durham, by attending the Memorial Service in Chapel, and we were pleased to see so many Students, Sisters, and Nurses present. We noticed, besides, the Treasurer, Dr. and Mrs. Perry, Mrs. Bowden, Mr. Dunn, and Dr. Fawcett. The service, reverently and impressively rendered by the Choir, was conducted by the Chaplain.

The first portion of the Funeral Service was conducted yesterday at one p.m. at St. George's Church, Hanover Square, by the Rector, Rev. David Anderson. The opening sentences were read as the remains, preceded by the Choir, were conveyed to the chancel steps. Immediately following the body were Herbert and Frank Durham, Mr. Frederic Durham, and another brother of the deceased, and Mr. Hickson, son-in-law. The body of the church was occupied by a large and distinguished congregation, amongst whom we noticed Mr. Lushington, Mr. Christopher Heath, President of the Royal College of Surgeons, Sir William MacCormac, Mr. Bryant, Dr. Pavy, Dr. Wilks, Mr. Henry Power, Dr. Braxton Hicks, Dr. Cullingworth, Mr. Howard Marsh, Mr. Croft, Mr. Henry Irving, Mr. Bancroft, Sir William Broadbent, Mr. Harrison, Sir Richard Quain, Mr. Lockwood, Mr. Constantine Holman, Dr. Pye-Smith, Dr. Taylor, Mr. Howse, Sir W. B. Dalby, Mr. Davies-Colley, Mr. Willett, Dr. Goodhart, Mr. Groves, Mr. Clement Lucas, Dr. Hale White, Dr. Fawcett, Dr. Galton, Dr. Sidney Turner, Mr. Sutton Townsend, Mr. Blatherwick, Mr. Rand, Mr. Ray, Mr. Tom Bird, Miss Victoria Jones, Sister Cornelius, Sister Luke, Mr. Pendlebury, Dr. Hamilton, Dr. W. J. Scott, Dr. Horrocks, Mr. Golding-Bird, Mr. Jacobson, Mr. Symonds, Mr. Lane, Dr. Brailey, Mr. Higgens, Mr. Rowell, Mr. G. B. Smith, Dr. Starling, Dr. Campbell, Mr. Bolus, and many other well-known people, together with a number of present Guy's Students. During the service, the hymn "Now the Labourer's task is o'er" was sung, after which the cortége left the church while the organist played the "Dead March" from "Saul." The last rites were performed at the Crematorium, Woking Cemetery, to which the funeral party proceeded by train from Waterloo.

A General Meeting of the Students' Club will be held in the Anatomical Theatre, on Tuesday next, the 14th instant, at 4 p.m., to pass a vote of sympathy with Mrs. Durham. Dr. Hale White has kindly consented to take the chair.

On Thursday last, Lord Playfair presented a Bill for the reconstruction of the University of London, which was read a first time. We take this opportunity to remind those of our readers who are members, that Convocation is announced to meet on Tuesday next, when the "Bumpus" party will once again make effort to oppose the Senate's recommendation of this much needed reform.

We have forwarded to Parsons the sum of twelve guineas, being the amount subscribed to the fund on his behalf, which was closed on Saturday last. *The Librarian desires to acknowledge a donation of 5s. each from Messrs. A. Allport, W. E. S. Cobb, and J. P. Pendlebury.*

Calendar of Coming Events.

May 11th.—Guy's Hospital Bicycle Club. To Windsor, from Hyde Park Corner. 3.30 p.m.
1st XI. v. Surbiton, at Surbiton. 11 a.m.
2nd XI. v. Croydon II., at Honor Oak Park.
„ 15th.—London University. Presentation Day. 2 p.m.
Guy's Hospital Bicycle Club. To St. Mary Cray, from Lee Green. 6 p.m.
1st XI. v. Hornsey, at Hornsey. 11 a.m.
2nd XI. v. London Hospital "A." Honor Oak Park.
„ 16th.—Guy's Hospital Rifle Association v. St. Mary's, Ilford.
„ 18th to 20th.—Inter-Hospital Bicycle Club run. To Brighton, starting from Greyhound, Streatham Common, at 10 a.m., putting up at Royal Oak, St. James' Street, Brighton.
„ 18th.—First XI. v. Crystal Palace, at Crystal Palace. 11 a.m.
2nd XI. v. Pleydell, at Honor Oak Park.
„ 20th.—Final Fellowship Examination.
„ 21st.—Cambridge Second M.B. Schedules to be brought to Medical Office.
„ 22nd.—Guy's Hospital Bicycle Club, to Moulsey, from Balham Station, at 6 p.m.
Guy's Hospital Rifle Association v. Royal School of Mines, at Runnymede.
1st XI. v. Dunstable Grammar School, at Dunstable.

Guy's Hospital Christian Union.

I.—The Annual Sermon

Is preached in the Hospital Chapel on the 3rd Thursday in October, at 4.30 p.m.

II.—The Weekly Addresses

On Thursdays, 4.30 to 5.15 p.m. In the Board Room over the Counting House.

May 16.—Rev. W. Halliday Thompson, LL.D. (of St. Mary's, Stoke Newington).—Address, "The Treatment of Eternal Life."
„ 23.—Rev. T. H. Darlow (of New College Chapel, Hampstead).—Address, "Sursum Corda."
„ 30.—Rev. C. H. Bowden (Chaplain).—A Devotional Address, "Ye call me Master and Lord, and ye say well; for so I am."—S. John xiii., 13.
June 6.—The Medical Prayer Union Annual Conference at the Council Chamber, Exeter Hall. A General Conference at 5.30 p.m. Tea and Coffee at 5 p.m.
„ 13.—Three Short Addresses by Members. C. F. Wakefield, Esq., in the chair.
„ 20.—Dr. F. Montagu Miller.—Address, "God's claim and our reasonable service."

Paddington Infirmary.

(284 Beds.)

RESIDENT CLINICAL ASSISTANT.

The Guardians of Paddington Parish invite applications for the above appointment.

1. Candidates for the post must be duly qualified and unmarried.

2. The appointment is for six months; and the emoluments are board and residence and an honorarium of twelve guineas, subject to the completion of six months' satisfactory service.

3. The duties are to assist, under the direction and control of the Medical Superintendent, in the diagnosis and treatment of cases, etc., and the making and preservation of clinical records.

Further information may be obtained of the Medical Superintendent at the Infirmary, No. 285, Harrow Road, W., on or before the 14th day of May, 1895, between the hours of 9.30 a.m. and 1.30 p.m.—By order,

HENRY F. AVELING, Clerk to the Guardians.

Scheme for the Appointment of a Clinical Assistant.

1. That, subject to the approval of the Local Government Board, a Resident Clinical Assistant be appointed by the Board of Guardians.

2. That Candidates for the appointment shall be duly qualified Medical Practitioners.

3. That each gentleman shall hold office for six months, subject to a month's notice on either side.

4. That his appointment shall not affect existing conditions, nor the Regulations now in force for the administration of the Infirmary.

5. That he be provided with the usual residential allowances, namely, board, lodging, and washing, and awarded an honorarium of Twelve Guineas, subject to his completion of six months' satisfactory service.

6. That he shall conform to the Regulations of the Local Government Board and of the Guardians, and act generally under the direction and control of the Medical Superintendent.

7. That, during the absence on leave of the Medical Superintendent or Assistant Medical Superintendent, he shall render such extra assistance to the Acting Medical Superintendent as may be required, without additional remuneration.

8. That he shall assist at the Workhouse, without additional remuneration, when the control of the Medical Work of the two Institutions is vested in one officer.

Contributors are informed that there is nothing of importance connected with Guy's for which we cannot find a place in our columns.

Introductory Lecture to the Course on Materia Medica and Therapeutics.

DELIVERED AT GUY'S HOSPITAL, MAY 5TH, 1874,
BY W. MOXON, M.D., F.R.C.P.,
Physician to the Hospital.

GENTLEMEN,—A suitable introduction seems so important, that it is almost dangerous to give one's mind to it, for fear the thing to be introduced should prove not equal to the preceding flourish. Knowing this, I have looked around me at the beginnings of things, to try to get a general notion of the process of introduction; to follow, if possible, its proper rules on this occasion. But I soon found that, if I gave myself to this inquiry, I might never get to the materia medica at all: things begin so vastly differently, according to their nature and circumstances. Still, before giving up, I came to apprehend, in a vague sort of way, a track of broad distinction running between the two great groups of things—the productions of Art and the productions of Nature. One could not help observing that artistic products come in with much prelude; so that, for instance, in an oratorio or opera, the composer leads into his overture the choicest staves of his best movements, to sharpen expectation of its various excellencies, and he enlivens these pet staves in his most enticing manner. But it struck me that it is quite otherwise in the works of Nature: her developments appear so unobtrusively, that the promise is never greater than the performance; for instance, when she is introducing her materia medica, how dry are the bracts in which she enwraps the rhubarb that is about to be. Such a dry beginning I would especially desire to make, knowing as I do that many students of taste would prefer swallowing materia medica to hearing about it, and chilled as I thus am by my sense of the unpopularity of my subject.

The subject of materia medica comprises pharmacognosy, pharmacy, and pharmacodynamics, or therapeutics. I well remember the sigh with which I learnt that bewildering truth, and the rebellion I felt rise within when I found that "pharmacognosy" (derived from *φάρμακον*, a medicine, and *γινώσκω*, I know) treats of the origin, properties, varieties, quality, and purity of unprepared medicines or simples. This, I said, must be very important, if you want to trade in drugs—to be a drysalter or colonial broker, for instance. Then, pharmacy (from *φάρμακον*, a medicine) treats of the collection, preparation, and preservation of medicines. This, surely, it seemed to me, must be very much to the point between wholesale and retail chemists, who ought not to cheat each other and the public; and if they cannot be trusted, then the Home Office should look to their behaviour: put a tax on and keep analysts, as they do with tobacco and beer.

Then, pharmacodynamics or therapeutics (from *φάρμακον*, a medicine, and *δύναμις*, power; and from *θεραπεύω*, I cure) treats of the effects, uses and administration of medicines in the cure of diseases. Reading this, I was soothed; and it seemed to me that this is so valuable a branch of knowledge, that I could even wade through the pharmacognosy and the pharmacy to get at the pharmacodynamics or therapeutics. For at that time it was my first year: I was like other first-year's men, rather fresh from the nursery, and my notions were much what I had been brought up in at home. How should it be otherwise with a first year's man? His medical experience is of the measles and cutting his teeth; and he remembers, doubtless, that then mamma or nurse would say, "Here comes Mr. Johnson, dear, to make you well"; so he thinks doctors send things to make you well, and hence the powers of remedies appear to his young mind as the chief object of a doctor's study: indeed, I remember a glow of satisfaction at the size of my Pereira—three big volumes. This appeared to me to foreshow the greatness of the armoury I must learn to wield. True, I saw that the pathology was a big one, too, and contained a terrible list of obscure and insidious diseases; but my ardour fancied it might be that diseases had grown so numerous and so sly in their onset by reason of the many and great remedies that had been brought by the doctors to bear on them, leaving them no chance but to come like thieves. That view has undergone large modification in the years, full of experience, which have separated me from the innocence of first year's manhood, and made it competent for me to address you as one of the aged and much knowing. But I have so much love for that old childish notion, that I will not slight it; for one thing I believe sincerely, that the phases of faith in remedies should be developmentally successive, without abrupt breaks, that you may continuously grow into that masterly doctor I wish you to become. If there be any sense in which the child is father of the man, it is surely to infer that the man should hold in filial respect all that was good in his earlier stages. When the elder regard the value of their former lives, they are safe guides: but when they conceive that their own lives were wasted by comparison with some new thing that they used scarcely more than half to appreciate, then they are the most insecure of guides, for with the inflexibility of age they unite the unappeased desire for something new, which makes youth unstable. Let us mark this truth, for the old fault of medicine is, that its age is not honoured within itself; hence it cannot form heart-wood, and rots periodically, like an annual plant. Physicians and surgeons, themselves somewhat in years, and too conscious that they often failed, hear of the wonders of the recent school of scopes, and graphs, and ometers, and, not sufficiently honouring their own sound clinical knowledge, they lend the weight of their position and character to force laws upon students, compelling them to pass hours and days in poring over microscopic details which are, to all intents and purposes, just as useful as the science of butterflies or of quantics for practically benefiting the sick. Meantime those students learn next to nothing of clinical medicine, and

so, for want of valuing its older acquirements, medicine behaves like the little ones, who let go one handful to grasp another, as if in second childhood.

To maintain a reverential and respectful bearing towards what is good in preceding stages is essential to sound progress: I say to maintain, not always to use, reverence, for we have to be practical actors in a world which subsists by changes, as well as correct in those feelings which give character to our own part in those changes. Not only must individual persons be thus reverential, but likewise trades, crafts, and professions must deal in a similar spirit with the earlier history of their own development. In thinking, as therapeutists, of the history of therapeutics, we must (1) deal fairly with our predecessors, and (2) not think too much of ourselves. Some day, you know, we shall be historic ourselves; that is the louder ones amongst us—a chastening thought, when you reflect what sort make the most noise. It would puzzle Max Müller to say into what form of solar myth Holloway's pills and lunatic asylum will enter. In those far future times our very best may seem strange. Cannot you fancy the lecturer in 2874, of the threatening era of what I may call Panteutonic Buddhism, beginning somehow thus: "The earliest age is known as the Scopes-age, from the name of the many kinds of instruments worn by physicians. Thus, they had on their eyes things called microscope, the nature of which is now unknown, as the records of the period were printed on bad paper, and were worse bound; but they could make the smallest trifles come to sight. To spy through these at the excretions was supposed by the ignorant patients to have a magical healing virtue. These instruments were said to magnify, a word meaning to make great; but it was afterwards found out that the things put under were really made no greater than they were before. How this strange error prevailed we cannot now understand, but it has been suggested that the constant wearing of microscope prevented the physicians from being able to see the real relative size and importance of things. At the same early period, doctors were not considered full dressed unless they wore on their ears pipes of wood of ornamental design, called stethoscope; and it is said they would crowd in dozens to hear an unusual squeak or whiz, which had in itself no real relation to the patients' suffering and danger; but the poor patients thought all the while that they received great benefit from this. Besides these, there were many other scopes; but for mention of them I must refer you to the historical lectures, in which you will find it shown clearly that these delusions were but part of the universal trust in machinery which led to the downfall and decay of the primitive and almost unknown form of civilisation, to which I must apologise for so long directing your attention." Of course, all this will do scant justice to Laennec or Dr. Beale; but the abuses of our time will appear in shapes we little expect when our successors have the sun with them and we are in the shade, viewed by the best antiquarian perspicacity of the time; and when they cannot clearly see us, withal the sun is there to help them, they will say we are in the dark ages, where the forms are a few outlines, and the colours purple. But let us turn to past history.

Therapeutics is the oldest of the branches of medicine, and it is perhaps also the least respected; at any rate, I find that Garrod says it is the most backward department of a possibly scientific pursuit, which medicine is always becoming. But it, nevertheless, is clearly traceable in history that pathology and the other properly scientific parts of medicine arose as the servants of therapeutics. There were two stages of pathological inquiry. In the first, the immediate aim of the study of disease was the cure of the pathological state; the pathology was commonly invented to suit the therapeutics. In the second stage, which is of very recent origin, the object is so different that the science deserves to be called by a new name; for it is all the way off that other old pathology that astronomy is off astrology, so that you might call it pathonomy if you liked. This is the study of diseases directed towards the knowledge of the pathonomical state as a pure matter of knowledge. It is a noble study. It is good for society rather than for individuals. It lights up the darkness where -opathies fungate. It is communicable, and will endure the full light of inquiry; it grows in society—in the Pathological Society for instance. I say, it is the noblest branch of medical science. It is noble enough not to fear the truth. And this is the truth, that it is not of much good for healing the sick; I mean, for the individual doctor healing the individual patient, for the direct service of the one in serving the other. It may be of service, but that is not its direct aim. Something like those maggot-feeding birds that may do good to our crops while only thinking of filling their own. Suppose old Hippocrates woke up and went to the Pathological Society. I can think what he might say with some force. He might say, "All this is very interesting; it goes beyond my time in its way. I used to think a little in the same direction. But in all this you are but showing the truth of what then kept me from carrying the matter farther—that it does not help you with synocha and pneumonia. I advise you to watch what management and medicine are good, as we did in the old Asclepias by the sea."

However ill it may sound, you must bear to be told not to be too scientific. And this is why. Because you will have to deal more with the unknown than with the known. And science is extremely bad at dealing with the unknown. Science teaches you to walk firmly on solid grounds, with contemplative front and eye sublime, etc. But therapeutics require you to swim or fly, as it were.

It is because you must deal with the unknown that you must not be over-scientific. You must possess a quick invention, like an artist's invention, which shall follow inspirations where science declares the footing uncertain. There is no doubt that Trousseau is quite right when he urges that the ultimate aim of the doctor is to become an artist. Let me quote from his lecture on "What is

Clinical Medicine?" He says: "Every science touches art at some points. The worst man of science is he who is never an artist, and the worst artist is he who is never a man of science. In early times, medicine was an art which took its place at the side of poetry and painting. To-day, they make a science of it, placing it beside mathematics, astronomy and physics." Again: "In medicine, do not confound art and science. All cannot become artists, but persons of the most ordinary intelligence can make acquisitions in science." And again: "But we will never exact more than scientific knowledge, for the rest is a natural gift. Take care not to fancy that you are physicians as soon as you have mastered scientific facts. They only afford to your understandings an opportunity of bringing forth fruit, and of elevating you to the high position of a man of art."

I think nothing can be more vital to our interests than the just apprehension of the great truth thus stated by the great artist Trousseau, from his point of view. I would only diverge from his lead when he goes on to indicate that our aim is to become artists, and that because art is lofty. I have nothing to say against the motto "Excelsior" in it proper poetic sphere; but we must come out of poetry in real life, and we must be artists, as he calls it, not because art is high, but simply to try to cure sick people. Understand, please, that I am not going to doubt that our art is high. How not? Are we not artists in jalap and calomel, skilled, too, to form designs upon our patients in Epsom salts, senna, and rhubarb—a high art, of course!—and ever advancing, freshened by the brilliant productions of that august body, the General Council of Medical Education and Registration for the United Kingdom. If you doubt it, look at the appendix to their Pharmacopœia, and see there the suppositoria acidi carbolici cum sapone, or that last triumph of the Council, aqua chloroformi, which, as I shall probably not allude to it again, I will discharge my duty upon by describing at once. "Take of chloroform ʒi., distilled water twenty-five fluid ounces. Put them into a two-pint stoppered bottle, and shake them together." Who can doubt the art here? and, this being art, who can doubt that Trousseau is right in speaking of elevating you to the high position of a man of art? But, perhaps, if we were spared a little such art as this, we should more directly feel our way towards that which, I cannot help thinking Trousseau fails somewhat to rightly touch when he calls it art: I mean feel our way towards that mastery of a constructive plan in our management of the sick and his attendants and circumstances, which is needed to make us accomplished and efficient medical men. For this, you want sympathy with the sufferer, energy of character, and fertility of resource. You may call it art if you like. All great artists have sympathy, energy and fertility; but you see a deal of art without these, and for instances I need not again go to the Appendix of the British Pharmacopœia. I say, a constructive plan in the management of the sick, a clear perception of the proper aim, or at least of its direction, and power to bring all the attendant conditions of the patient, as well as his frame, bodily and mental, into movement in the desired direction; doing all that is humanly possible, and meaning earnestly to do a great deal more—for this end, the pathology of the Pathological Society and of the *post-mortem* room will afford you very little direct help. I lectured on pathology not long ago, and then it was my duty and pleasure to recommend pathology in my introductory remarks. Among the recommendations I gave it, this was the greatest, if not the sum, of all. Pathology creates the doctor as distinct from the nurse. Now I shall tell you that therapeutics should make the doctor a greater nurse than the nurses; so that all that is done by the nurses the doctor does by means of them. No doubt, without nursing talent, you may be a very good pathologist, and no doubt without pathology you may be a very good nurse. I do not bate a jot of the recommendation I gave pathology. I hope my able successor, Dr. Fagge, will urge his recommendation still more forcibly. Pathology gives you a way of knowing what is happening and going to happen in your patient; and the public expect that of you. I shall take leave to pity you much, if you do not get a good knowledge of such pathology, otherwise you will be ignorant and unstable; and, if you have any conscience, you will be full of fears that others better informed than yourself would conduct the patient's case better than you are doing. So you will take your unmerited fees in a properly nervous perspiration, suspecting all the while that the patient's aunt is strongly recommending Mr. Johnson. It is for your own good that you learn pathology, so that you may have sound knowledge to rely upon when rivalry outside and weakness within shall shake your nerves. Here is the difference, then: pathology serves to give confidence to yourself; therapeutics serves to cure your patients, and you will find that is what your patients want. They do not care about the interesting *bruit de pot felé* or *de diable*. After a course of pathology and auscultation, so long and close that you have lost your memory of everything else, it gives you quite a turn to find out how little your patient cares about it. It seems very hard. It took you so long to learn. Perhaps it was almost all you did learn at the hospital, yet the patient thinks very little of it. You have made a great diagnosis, and, with a flush of interest almost proud, you tell him he has got a tuberculo-pleuro-pneumothorax. Instead of being satisfied like you, he goes on looking big eyes at you, as if he had received nothing at all. Perhaps you explain his case to him, and are then put quite out of countenance at his pathological apathy, and are beginning to think him an ungrateful creature. But you must remember the pair of you are not on the same footing in the affair. You wanted to know what is the matter to get a sound scientific position about it, and you naturally expect him to go with you into the little business with all pleasant interest in his diseased changes which science has taught you to take. He, on the other hand, naturally expects you to join at once

and warmly in that want of relief which is his one passionate desire. You see, in short, that the trouble is outside of you and inside of him, and that makes a difference which, after a course of scientific pathology, it needs always quite an effort to see; but, if you do not see it, it will likely be sent into you in two or three rough lessons.

The patient is looking for your therapeutics. He wants your medical art, and you will be judged by him according to your works. You have now to think of his occupation, his rest, food, drink, and sleep; his comfort, his ease from pain. Now for the artist who can, with a few bold lines, throw the nursing into fit arrangement, and then touch up the lights with a well devised mixture. Your science gives you a little dry dark stuff to deepen the shadows; do not put in too much. What you want is energy in cheerful device, and this is helped by a nature bent on doing all, even the very least that can be done for the patient. And it grows into an experience which the public deeply appreciate and want; and the article they want cannot be made any other way; too much science goes rather against it; it spoils your liver, and makes you think of yourself instead of your patient. The first quality of the young doctor is the tendency to nurse. Over the clinical room should be inscribed, "Nobody not born a nurse should come in here." For success in the world, I see that a good nurse with little science is better than a great university man who is all nowhere with those little points of posture and diet which make a sick person suffer less. The world chooses the kind-hearted nursing man. They have a shuddering hatred of the mere pathologist, winding, with his questions, about in their bodies like the first of the worms they have always expected to come to. Of course, the medical nurse must be efficient in point of knowledge. What we have to aim to secure is a proper proportion of knowledge, and activity, and sympathy; that is, of matter, force, and agreeable form in the construction of of character.

(To be continued.)

Guy's Hospital Dental Department.

Practice during April, 1895.

Gold Fillings		145
Amalgam ,,		281
Osteo ,,		
Perm. G.P.,,		
Artificial Crowns		22
Dentures		7
Dead Teeth		37
Scalings		19
Regulations		1
Attendance for Extraction under Anæsthetics		224
,, ,, without ,,		640
Total		1376

Weana Schnitz'l;

OR,

STUDIES IN LITTLES.

No. III.

The ways of our ancestors are still in vogue—but sometimes reduced are they to details—for instance, "*blood-letting*," once so much the fashion; whilom the foster-parent of many a quaint adjective; again, almost completely a dead-letter. Phlebotomia rediviva—not only as a scientific means of treatment, but even also as a scientific helpmate to certain diagnoses—perhaps though, of but little use yet with our nineteenth-century ignorance in all its crassness.

In old days, blood by the pint; nowadays, by the cubic centimetre—yea by the cubic millimetre. How many Corpuscles red? How many Corpuscles white? How much Hæmoglobin? How much Fibrin? Of what Specific Gravity? Of what sorts are the red, of what sorts are the white corpuscles? In old days, the clot and the naked-eye; nowadays, the detail and the microscope! Perhaps Accuracy *versus* the Shrewd Guess—who knows! . . . . .

A Physician and a Surgeon have recently been raised to the Peerage of Austria. . . . . .

Typhoid and Tuberculosis—much harried theme—will it be so in the future? Bacteriology steps in, and lifts a corner of the veil: with enough decision to gain entrance into Text-books. The whole in a nutshell—Typhoid Bacilli in the urine—ofttimes recognisable with some probability with the microscope alone—certainty, of course, only comes with the several distinctive properties, shown by cultivations made in the well-known varied ways. Perhaps of little use to the bacteriological neophyte—unversed in the similarities 'twixt B. typhi abdominalis and B. coli communis—still 'tis no backward labour, even though bereft of that sweet simplicity that erst did cloak the aftercoming complexity. . . . . .

And so with the "spots." . . . . .

Tubercle again—this time in the urine, also again. Given the following, would the embryonic medical ward clerk fail to find bacilli if present? This is no common riddle. Data—(1) A centrifuge, driven by electromotor at 7,000 revolutions per minute. (2) The patient examination of some 40 or 50 cover-glasses. (3) ——but what more is wanted? so let there be no "(3)." For, *of course*, he (the M.W.C.) has the practised, necessary, and diligent eye of the tubercle bacillus hunter. . . . .

With us, records of cases are chiefly in the hands of the inexperienced fledgling, here they are far more under the eye of, and sprung from loins of the vocal cords of the senior—shall we say—student. No doubt the cause of the excellent and detailed descriptions of cases which are oft to be read—not in English nor in French. He, that is here labelled "Senior Student," is not such as your Clinical—his soul has already flown

higher. He is dominated by a "Professor," and has varying relations with the Herren Dr. Assistenten—if indeed he is not one himself. The Professor suggests that as certain points concerning certain diseases come actually within the limits of our ignorance: or that as he has had an interesting case, or series of cases of the sort—it would be well to enquire into these or subsequent cases. When in difficulties, to the Professor! for he is ever ready with an advice that has some real worth; a criticism that is apt; a detection of a fallacy that lurks. That cases are thus thoroughly thrashed out, with the true scientific spirit, and with an ardour towards veracity, newness, or substantiation of the old, comes somewhat from the M.D. system. In England, except for the older Universities, the doctor's degree is given through examination: indeed, some Universities go through the annual farce of presenting medals to men, who may either be *among* the *best* or *among* the *worst* of the candidates. Here, as with the older Universities, a Thesis is required. For a Thesis the writer must have substance for "copy." But this will make "copy" for another Schnitz'l. Also, Adieu! Auf wiederschauen!

Wien. Δ.

Pass List.

Final Conjoint Examination, April, 1895.

MEDICINE, SURGERY AND MIDWIFERY.

*Mumford, W. G.

MEDICINE AND SURGERY.

*Lane, J. G. O. H.
Statham, C. J. B.
*Winter, J. B.

MEDICINE AND MIDWIFERY.

Dolman, A. J.
*Peake, W. H.
Wakefield, C. F.

SURGERY AND MIDWIFERY.

*Moffat, H. A.
*Tresidder, P. E.

MEDICINE ONLY.

Carden, W. A.
Coleman, E.
*Croneen, S.
Graham, S. G.
Hughes, S.
*King, T. P.
Moon, R. O.
Philipps, A. E.
*Pitt, W. C.
Rowland, F. W.
*Wilkins, J. C. V.

SURGERY ONLY.

Beven, O.
Gocher, G.
Lincoln, C. H. S.
Milbank-Smith, H. J.
*Pakes, W. C. C.
Shorland, E. T.
*Van Someren, E. H.

MIDWIFERY ONLY.

Beadnell, C. M.
Covernton, C. E.
Hewetson, H.
Huckle, A. H. H.
Nicholson, T. M.
Reed, J. C. G.
Richmond, B. A.
Turner, A. Scott
Wise, H. M.

*Denotes completion of examination.

Second Conjoint Examination, April, 1895.

(Under Regulations dated January 1st, 1892.)

ANATOMY AND PHYSIOLOGY.

Berncastle, H. M.
Berry, T. P.
Chapman, C. L. G.
Clarke, A. E.
Dupigny, J. E.
Eason, H. L.
Fell, R.
Fox, H. E. C.
Goddard, E. G.
Heath, F. H. R.
McGavin, L. H.
Martin, F. J. H.
Milton, W. T.
Pennington, S. B. C. C. A.
Ruzzak, S. A.
Telling, W. H. M.
Turner, P.
Walker, F. E.

(Under Regulations dated October 1st, 1884)

ANATOMY AND PHYSIOLOGY.

Ambrose, A. C.
Crapper, H. S.
Handson, L. E. C.
Mussellwhite, W.

ANATOMY ONLY.

Gibson, C. W.
Parsons, J. E. H.
Payne, J. L.

PHYSIOLOGY ONLY.

Body, T. H.

University of Cambridge, April, 1895.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART I.

Field, G. H.
Key, B. W. M. A.
Ransome, E.

PART II. (Unofficial List).

Beddard, A. P.
Burrell, L. C.
Stewart, C. Balfour.

University of Durham, April, 1895.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE FOR PRACTITIONERS OF FIFTEEN YEARS' STANDING.

B. Jones, L.R.C.P., M.R.C.S., D.S.Sc. Vict.
H. A. Latimer, M.R.C.S., L.S.A.

EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE AND BACHELOR IN SURGERY.

Frazer, E. E.
Fothergill, E. R.
Gocher, G.
Peake, W. H.

From the Gazette's Special Pathologist.

ALL specimens — particularly those of solid tissues— should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exupation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

H. E. P., LOUGHBOROUGH.—The breast shows a typical scirrhus carcinoma, with many secondary nodules diffused through the breast and along the submammary lymphatics. The growth is not freely removed at the lower and inner quadrant of the organ. Nipple unaffected. Embedded in the breast is a small fibro-adenoma, and a few retention cysts are found in the atrophied part of the glandular substance.

B., TUNBRIDGE WELLS.—No tubercle bacilli could be found in the sputum.

G. S., BLOXHAM.—The growth is a carcinoma composed of large alveoli in a loose scanty stroma. It shows evidences of rapid enlargement.

E. R. R., DULWICH VILLAGE.—Tubercle bacilli are present in the sputum in large numbers.

K. S., GRAVESEND.—The tumour has the structure of an ordinary uterine fibroid, and there is no evidence of malignant disease in it.

P. E. D., KIDDERMINSTER.—The tumour shows lobular induration of the breast tissue with moderate dilatation of the smaller ducts. There is no indication of malignant disease.

W. E. T., NOTTINGHAM.—The growth is composed of delicate vascular processes covered with columnar epithelium, and traversed by large dilated vessels. There is no muscular tissue present to indicate invasion of the deeper parts, but the growth is undoubtedly malignant, and may be classed with the cylindrical-celled epitheliomata of a villous type.

G. P. W., MELTON MOWBRAY.—Tubercle bacilli are present in the sputum in fairly large numbers.

G. S., BLOXHAM.—The material (white) consists of degenerated pus-cells and inspissated mucus, vaginal epithelium, granular matter from broken down cells and putrefactive organisms. There are no particles of growth or cells of a malignant type. The material (red) is of a similar nature, but mingled with blood. In neither specimen is there anything to warrant the diagnosis of cancer.

S. W. McI., SOUTH PETHERTON.—No tubercle bacilli could be found in the sputum.

R. C., WINDLESHAM.—No tubercle bacilli could be found in the sedimented urine. Microscopically the sediment consists of pus-cells, bladder-cells, and others of a probably renal origin. The large number of epithelial cells and the relative paucity of the pus-cells confirms the observation that the lesion is not tuberculous.

E. H. B., STREATHAM HILL.—The culture shows a very impure growth. On microscopic examination bacilli are observed, in some respects resembling the Klebs-Löffler bacillus, but much contaminated. The diagnosis is doubtful.

PATHOLOGIST.

St. George's Hospital Medical School.

A COURSE of Special Lectures on "Diseases of Tropical Climates," will be delivered by Patrick Manson, LL.D., M.D., Lecturer on Tropical Medicine to the School, in the Medical School of St. George's Hospital, on Tuesday, May 21st, and every succeeding Friday and Tuesday, till July 26th, at 5 p.m. each day.

The course is intended for medical men intending to practise in the Tropics or in Eastern Asia. It will embrace the Fevers of warm climates, including Malarial Fevers, Dengue, Mediterranean Fever, and other unclassed varieties, Dysentery, Sprue, Liver Abscess, Filariasis (Elephantiasis, Chyluria, &c.), Ankylostomiasis, Guinea Worm, Bilharzia and other Parasites, Beri-beri, Tropical Skin Diseases, &c.

So far as practicable it will be illustrated by Living Specimens, and by demonstrations of parasitic organisms associated with these diseases.

The fee for the course will be three guineas.

Application should be made to the Dean of the Medical School, St. George's Hospital, S.W., from whom cards of admission may be obtained.

ISAMBARD OWEN, M.D.,
Dean.

Epidemiological Society of London.

THE next Meeting will be held at 11, Chandos Street, Cavendish Square, on Friday, May 17th, at 8 p.m., when a Paper will be read by Professor Lane Notter, M.D., on "Soil as a Factor in the Production of Disease."

H. TIMBRELL BULSTRODE, M.D.,
4, The Mansions, Earl's Court, S.W.;
SIDNEY COUPLAND, M.D., F.R.C.P.,
16, Queen Anne Street, W.,
Hon. Secs.

Sport.

Cricket.

GUY'S v. BECKENHAM.

This, the usual opening match of the season, was played at Beckenham on Saturday, May 4th, and resulted in an easy win for the home team. Perks' winning the toss, elected to go in; the wicket was in very good condition, and the weather delightful; but, owing to want of practice, we failed to make proper use of it; in fact, the only wickets that put on an appreciable number of runs were the last two. Pike batted well for his 35, not out. Loud also made good use of his time and put together 20; then Francis went in, who had unfortunately missed his train, and, with Pike, brought the score up to 117 before he was caught out, and thus the innings closed before lunch.

After lunch, Shorland and W. I. Hancock went on to bowl for us and at first, wickets fell quickly, Shorland bowling two in his second over, and then Hancock got rid of Cooper l.b.w. After this, however, matters did not go on so well for us, which was owing entirely to our fielding; both Northcote and C. J. Inglis were given fresh lives (the latter more than one) before they got well set. Northcote batted in excellent form after his first chance, and had bad luck in not reaching his 100. C. J. Inglis also hit well, but experienced a good deal of luck in getting his 147. The other wickets did not give us much trouble, and we were very glad to have them all out by 5.30. This left us about an hour's play, so we started on our second innings with the score as below. Owing to the short space of time to get up a team, we were obliged to call upon several of last year's XI., who are no longer available, and so had little chance of trying new men. A trial match was got up on Monday afternoon for this purpose, with a very fair result. A. E. Clarke both bowled and batted well; Humphrey also batted well; Goddard bowled very fairly considering the wind, and several others showed promise, and even keenness—rather exceptional for Guy's cricketers—so very likely we may yet make a good team, and keep up the reputation of the Hospital. The score:—

Guy's. 1st Innings.		2nd Innings.	
W. I. Hancock, c Matthews, b Street	12		
A. Perks, b Street	0	not out	26
R. B. Stamford, b Street	10		
E. T. Shorland, c Mathews, b Aste	4		
N. H. Pike, not out	35	b Northcote	8
K. B. Alexander, b Street	0	c Inglis, b Northcote	11
A. C. Ransford, b Street	1	b Northcote	0
E. G. Goddard, c Cooper, b Street	2	b Northcote	11
F. H. Loud, b Lee	20		
C. J. Francis, c and b Street	19		
G. Stillwell did not bat	0	b Baker	0
Extras	14	Extras	6
Total	117	Total	62

Beckenham.

1st Innings.

C. O. Cooper, lbw Hancock	4
F. N. Lee, b Shorland	9
H. B. Street, b Shorland	0
P. Northcote, b Hancock	94
J. Aste, c Goddard, b Shorland	11
C. J. Inglis, b Hancock	147
S. W. Marshall, b Hancock	12
A. M. Inglis, b Hancock	0
B. S. Mathews, c Stillwell, b Perks	15
S. G. Layman, b Hancock	18
W. B. Baker, not out	10
Extras	20
Total	340

Guy's Nurses' Lawn Tennis Club.

We have had much pleasure in receiving the card of this Club, which has now become *un fait accompli.* The following are the officers of the Club. President: Mrs. Shaw. Honorary Secretary: Miss Parrett. Committee: Nurses Blake, Palmer, Hodges, Nutt, Tidy and Yeaxlee. Honorary Members: Miss F. C. Nott-Bower, Mrs. Bowden, Mrs. Lane, Miss McLeod, Mrs. Perry. The following have already become members: Nurses Acheson, Blake, Bones, Barnes, Cooke, Coombs, Douglas (G.C.), Douglas (L.), Fricker, Grant, Herne, Hills, Halstead, Hodges, Morris, Markland, Moore, Naters, Nutt, Orde, Pritchard, Palmer, Powell, Rickwood, Seeley, Skerman, Tidy, Traill, Weymouth, Way and Yeaxlee.

We learn from the few necessary rules that the annual subscription is fixed at 2s. for members; that the wearing of tennis shoes is compulsory on the Courts; and that each member is allowed to invite a nurse or probationer (in Guy's Hospital Uniform), but not private friends.

We understand that the L. B. & S. C. Railway have readily sanctioned the request made by the Clubs' Union to allow the Guy's Nurses to use the cheap tickets to Honor Oak Park.

Guy's Hospital Bicycle Club.

The first run of the season was held on Saturday, May 4th, in conjunction with the London Hospital Cycling Club. This was the "opening" run of our club, for which some smoking-room wit prescribed a large dose of M.M. c. M.S.

The London Hospital Cycling Club came down in force to the "Greyhound," Streatham Common, at 3.30, where two Guy's men had foregathered. Thence they travelled at their ease to Croydon, where in waiting were the committeemen and another wheelist. Thence by Riddlesdown and Warlingham to Godstone, where a descent was made on the Cyclists' Touring Club hotel for

tea. The cyclists' usual healthy appetite enabled all to do full justice to an ample meal, towards the latter part of which another Guyite rendered account of himself, which balanced the numbers representing each hospital. The ubiquitous Bruzand, Hon. Secretary to the United Hospitals and London Hospital Cycling Club, proposed, in the absence of any distinguished musical talent, an adjournment to the green, where Godstonites were doing battle with bat and leg-guards against some other-ites: wearying of watching the fall of wickets a challenge was issued and accepted, each team anxious and willing to maintain its respective hospital's fame and honour at the intense game known to our youth as Rounders. The Guy's team succeeded in rounding the square four times to nil. The return journey was commenced soon after seven, by the same route, everyone well pleased with themselves and each congratulating himself on his good fortune at being present in such pleasant company and under such favourable circumstances.

This is a very fair sample of what enjoyment may be had from our Club runs, and I wish most strongly to urge on all cyclists who have recently joined the Hospital, and not yet attended any of the runs, to make themselves known to any of the officers of the Club, and to join the Club on either its Saturday afternoon or Wednesday evening runs.

Also please to remember that the racing season will soon be upon us, and that the duty devolves on every racing man to uphold the honour of the Hospital in the Inter-Hospital Sports. Men must start training soon, if they wish to be in form for our own races, which will take place about June 10th, on the results of which will rest the selection of the teams for the races for the Inter-Hospital Challenge Shield.

Run cards for the season can be had now, and all information will be most willingly supplied on application to G. L. Eastes, Hon. Secretary and Treasurer.

Sporting Notes.

SWIMMING.

The annual general meeting of the above club will be held on Monday, 13th inst., when it is hoped that there will be a strong muster of swimmers. We understand that the St. Saviour's Baths have of late been largely patronised by Guy's men, and that our head-quarters are to be established there. This is very satisfactory news and augurs well for the club, which, by-the-bye, is as yet an extra Clubs' Union institution, and the annual subscription to which is 2s. 6d. Members of the club can secure cheap tickets from the Hon. Secretary—a further inducement to all swimmers to enjoy the privileges of active membership.

CRICKET.

The Past *v.* Present match arranged for Wednesday last was postponed, owing to the death of Mr. Durham, President of the club. The first eleven met a strong Beckenham eleven on Saturday last, and sustained a heavy reverse. But for the very bad fielding, which let off the powerful scorers on our opponents' side early in their innings, the match would have been a more interesting one.

BOXING.

Yet another attempt is being made to bring off a United Hospitals' Boxing Competition. We hear that up to the present Guy's, University and King's have sent in entries, the probable date of the fixture being the 22nd inst. The place of meeting is not yet decided upon. It will be remembered that the first competition was held in March, 1893, at the Store Street Hall, when Guy's carried all before them, winning four out of the five weights decided at the competition. Our representatives on this occasion were Messrs. Allport, L. G. Reynolds, W. M. Price, M. E. Tresidder, and D. A. W. Martin, the last of whom suffered defeat at the hands of D. Cary, of London. Further particulars as to the forthcoming meeting may be had of Mr. C. Roe, University College Hospital, Gower Street, who is Hon. Secretary of the United Hospitals' Boxing Club.

Appointments.

Bryden, F. W. A., M.R.C.S, has been appointed Honorary, Medical Officer to the Royal Surrey County Hospital, Guildford.

Floyer, W. W., M.B. Lond., M.R.C.S., has been appointed Medical Officer for the Thorpe Sanitary District of the Chertsey Union.

Sheen, A. W., M.D., B.S. Lond., F.R.C.S. Eng., has been appointed Assistant Surgeon to the Cardiff Infirmary.

Taylor, J. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health for the Methley Urban Sanitary District.

Births.

ENSOR.—On April 17th, at Windsor Place, Cardiff, the wife of Mr. Henry Collen Ensor, Surgeon, of a son.

STROVER.—On April 17th, at Sandy, Beds, the wife of Herbert C. Strover, L.S.A. Lond., of a son.

Marriage.

MITCHELL—BLACKWELL.—On April 23rd, at St. James's Church, Paddington, by the Rev. R. Mitchell, late Vicar of Wield, and the Rev. W. J. Sowerby, Vicar of Eltham, Ernest J. D. Mitchell, B.A., M.B., B.C., of The Grange, Eltham, to Kate Beatrice, widow of Edmund Alfred Blackwell, and daughter of the late C. F. Clements, of 3, Porchester Square, Hyde Park.

Death.

DURHAM.—On the 7th inst., at 82, Brook Street, Grosvenor Square, Arthur Edward Durham, F.R.C.S., Consulting Surgeon of Guy's Hospital, Member of the Council of the Royal College of Surgeons, in his 62nd year.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE' GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

MAY 25, 1895.

The Sustentation Fund.

WE understand that at the last meeting of the Court of Governors of Guy's Hospital it was determined to form a separate department of the Counting House for the establishment of a maintenance fund. Few of our readers are in ignorance of the fact that for some years past the gradual fall in the rents of agricultural land has caused serious anxiety to those responsible for the finances of the Hospital. Twenty years ago everyone prophesied that the fall would be but temporary, and even now there are some who believe that they see signs that the lowest point has been reached and that, with or without the introduction of various panaceas for "re-peopling the land," there is a brighter future for the holder of agricultural property. The greatest optimist will not, however, venture to fix the dawn of that happy day in the first half of the twentieth century. In the meanwhile, all those whose prosperity depends upon the rent they receive from their farms must make arrangements of a more or less permanent character, in accordance with the faith that is in them.

The individual landowner is justified in curtailing his expenses and waiting with what patience he can command for the golden future. But not so the trustees of a great charity like Guy's Hospital. The curtailing of expenses here would mean the withdrawal from thousands of poor people of one of the greatest blessings that the philanthropist has been able to devise, and from the nation at large the benefit it receives from one of the most practical centres of medical education in the United Kingdom. It is obvious that the only source to which the Governors can look to make up the deficit arising from their unlet farms is public charity, and it is in order to systematically appeal to this source and to make the needs of the Hospital more widely known that the new department has been established.

There is no doubt that the task before the executive is a large one, but we are used to hard work at Guy's, and the greater the difficulty the more pleasure in successfully coping with it. We understand that the annual deficit of several thousand pounds must be met in order that all the beds may be kept open. This is a large deficit, but tens of thousands are annually subscribed for institutions whose present work and past history cannot enable them to compete with Guy's for popular favour. The public has yet to learn that in supporting a hospital to which a medical school is attached, instead of subscribing to the special hospitals that abound, they are not only doing their best for the sick poor but are indirectly serving their own interests by helping the cause of medical education. In old Guy's men we have an army of willing instructors of the Public, and to them we confidently appeal to do all in their power to make the Maintenance Fund Department an unqualified success.

Angina Ludovici.

CLINICAL LECTURE BY DR. PERRY.

The lecturer remarked that after some consideration he had selected for the subject of his lecture the disease known as Angina Ludovici, the accounts of which in text-books were commonly somewhat brief and unsatisfactory. He then proceeded as follows:—

Having selected a subject, I naturally consulted Dr. Fagge's treatise on medicine, and there I found an account, very accurate as far as it went (as all Fagge's work are) but also very brief. He defines the disease as a diffuse inflammation of the tissues of the neck which may or may not be accompanied with œdema of larynx. I then remembered, in the obituary of Dr. Fagge, which appeared in our Reports, an anecdote of Mr. Hilton, how that being at the bedside of a patient suffering from this disease, he asked the general practitioner in attendance why the breathing was so laboured, and proceeded to answer his own question by saying that the pneumogastric nerve was implicated in the inflammatory process.

Dr. Ludwig himself thus describes what he terms "the new kind of inflammation of the cellular tissues of the neck." He says: "Along with symptoms which precede a rheumatic, or rather, an erysipelatous angina, there developes, sometimes on both sides, generally on one side of the neck, a hard swelling, commonly in the tissue which surrounds the submaxillary gland, more rarely in that which surrounds the sublingual or parotid. This cellular inflammation spreads and similarly affects all the cellular tissue which it involves, spreading at first towards the chin, even to the opposite side, then downwards to the larynx and backward to the parotid, at the same time that it swells considerably. It involves in like manner all the inter-muscular planes and the muscles themselves between the mouth and the hyoid bone. The tongue rests on a floor of hardened tissue, deeply congested, which becomes more especially prominent and like a bolster in the mouth, just inside the symphysis of the lower jaw. The power of opening the mouth is much curtailed, and attempts to do so are painful. The tongue thus rests on a floor which is indurated and reddened, and it is pushed upwards and backwards; the movements of the jaw and the power of swallowing and speaking are materially interfered with. . . . During the further course of the disease the skin over the tumour begins to get red, particularly in places, and if it have not previously occurred, in the interior of the mouth there appear deposits of phlogistic lymph. The swelling under the tongue becomes softer, as though serum had been poured out beneath the serous membranes and had partially coagulated. On the exterior, some parts have become locally softened and pit on pressure, and to the finger now give the feeling of crepitation, from the development of gas. Elsewhere a more distinct feeling of fluctuation is perceived, as if here and there it might come to active suppuration; this, however, does not actually take place, for the process either stands still or it recedes."

I may summarise the rest of his remarks as a description of gangrene and death in the "typhoid state."

As regards ætiology, Dr. Ludwig believed that an erysipelatous process underlay the disease, which either on account of "epidemic influences" or in consequence of some peculiar condition of the patient, was prevented from getting to the surface, and which then "determined to the deeper parts heterogeneous to its nature;" hence this gangrenous inflammatory condition of the cellular tissue was brought about: or it might be due to conditions proceeding from the nervous system as epidemic influence developes itself, so that the disease derives its tendency to gangrenous inflammation from the erysipelatous factor as in malignant carbuncle, and its tendency to induration and paralysis from the nervous factor, as in malignant parotitis."

The diagnostic points he makes are—first, the slight inflammation of the throat, which even when it exists disappears after a day or two; second, the peculiar wood-like induration of the connective tissue which will not receive impressions; third, the hard swelling under the tongue, with the bolster-like swelling around the interior of the lower jaw, of deep red or bluish-red colour; fourth, the uniform spread of the induration so as to be sharply bounded by a border of entirely unaffected cellular tissue; fifth, the escape of the glands, though the cellular tissue surrounding them is implicated.

I may now read to you my notes of a case of this kind that has been under my care in Clinical.

The patient, a male, æt. 16 months, was admitted on the 24th of April with symptoms of acute laryngitis, which, in the absence of any affection of the fauces or skin, was considered to be of the catarrhal variety. On admission, the temperature was 100·6, pulse 113, and respiration 60. There was evidently consider-

able obstruction to the entry of air into the chest, the lower ribs being drawn in with inspiration. There was stridulous breathing and slight cyanosis. Physical examination of the lungs afforded no evidence of broncho-pneumonia or pleurisy. There was no swelling or redness of the neck. On the 25th, the temperature was 102, and the breathing still rapid. On the 27th, the child seemed to be much better, the stridor having disappeared, and the temperature being lower (100). On the 28th, he was worse, with increased cyanosis, and a very feeble pulse. On the 29th, the right side of the chest was dull behind, but the dulness did not seem to be absolute, and loud bronchial breathing with crackling râles was heard both in front and behind. Hence it was thought that the pulmonary condition was that of consolidation. On the evening of this day the patient seemed rather better, but next morning he became suddenly worse and died about noon.

On post-mortem examination, the tonsils and fauces appeared to be quite normal, and the œsophagus was also free from disease. There was slight œdema of the arytæno-epiglottidean folds, but otherwise nothing abnormal was detected. There was, however, a diffuse suppuration in the deep cellular tissues of the neck. A continuous tract of purulent infiltration extended on the left side of the neck from the level of the pharynx down into the anterior and posterior mediastinum, and in the anterior mediastinum there was suppuration apparently in the thymus gland, and from this the inflammation affected the pericardium at the base of the heart, and on opening the sac a little lymph with a patch of redness was visible on its inner surface. The suppuration was chiefly on the left side of the neck, but there was also some suppuration at the upper part on the right side. The whole of the left lung was covered with recent lymph, and in the pleura were 12 ounces of pus. The lung was compressed and small, but was not further examined, as it was required for the Museum. On the right side there was no inflammation of the pleura, but the lower lobe of the lung presented large areas of hepatization, of red and grey colour, at its hinder part. Pus taken from the cellular tissue at the upper part of the mediastinum was submitted to bacteriological examination by Mr. Pakes, and yielded an almost pure cultivation of the staphylococcus pyogenes aureus. The colon at its upper part presented a "shaven-beard" appearance. The spleen weighed one and a half ounces, the liver fourteen ounces, and the kidneys two and a half ounces. Except as above described the viscera were normal.

I have to add two notes from Mr. Mumford, the Clinical Assistant's, report, viz., that the patient seems to have been well up to the day before admission, and that on the 26th he was noticed to have a slight discharge from his left ear. This was unknown to me at the time, and I regret that the petrous bones were not specially examined, because, though I do not think it probable, we might possibly have found the cause of the cellulitis in them.

Now, I think we may assert confidently that all cases of Angina Ludovici are of *septic* origin, and although it is true that pus is not invariably found, one cannot say that it is never present. An acute septic process is, however, often rapidly fatal before pus has had time to form, and, as we know in the case of anthrax, certain micro-organisms may have little pyogenic tendency.

Now as to the causes of this disease:—

First.—Traumatism in its wide sense. These cases belong to the surgeon rather than to the physician, and I shall only enumerate them as follows:—Cut-throat, tracheotomy and other operations about the mouth and neck, gunshot wounds and other injuries of these parts, and impaction of foreign bodies in the larynx. A good case illustrating the last named cause is the subjoined:—

Emma K., æt. 70, was admitted on July 22nd, 1891, under Dr. Goodhart for cellulitis of pharynx and chronic Bright's disease. She was well until the 18th, when she fell, striking her head and her shoulder. Dyspnœa ensued the next day. When admitted, there was tenderness with swelling on right side of neck. The skin over the sternum was inflamed. On laryngoscopic examination, the epiglottis was found to be œdematous. In the evening her breathing became worse, and while her larynx was being examined she became unconscious and died. Nothing abnormal beyond bruise on left forehead was found on skin.

P.M.—There was a diffuse inflammatory infiltration of the connective tissue outside the epiglottis, chiefly on the left side and extending down on both sides between the thyroid and cricoid cartilages. On the left side of the inner surface of the epiglottis there was a raised, soft, swollen patch one-half inch by a third, yellow in colour, due to inflammation. At one spot there was a mark, which the pathologist considered to have been produced by a puncture.

The spot referred to was close to the ventricle of the larynx. There was also a yellow staining of mucous membrane at a corresponding situation on the opposite side. There was no pus, but the connective tissue was swollen and yellow. It nowhere had a foul odour. Dr. Pitt, who made the autopsy, remarks :—"The most probable explanation is that there was some injury, due possibly to a puncture by a fish bone, or some hard, sharp particle, to the left ventricular surface, and from this ensued an early cellulitis, in consequence of the condition of the kidneys."

The following case, recorded by a surgeon of University College, is an example of traumatic cellulitis following a scratch, unless, indeed, the case be one of anthrax, the bacilli not being detected.

A male, æt. 49, was admitted with fulness beneath lower jaw, and on the right side of the neck a scab. Swelling rapidly increased, extending up the sides of the neck behind the jaw and on to the chest. Patient felt "hot and cold by turns." The swelling was pale, and glands not enlarged. Skin normal; no pitting on pressure, and no pain on palpation. Floor of mouth thickened, but tongue not raised. Temperature 97·8, and he did not feel very ill. Scab "like a variola pustule." Tracheotomy soon required, followed by surgical empysema. At autopsy, no pus but much œdema, chiefly of the glottis.—*Lancet*, 1893, vol. I., p. 1312.

Next we come to cases due to extension of infection from the neighbouring parts, *e.g.*, sores in mouth (mercurialism), tonsillitis and laryngitis in diphtheria, scarlet fever and measles, suppurating glands in neck with or without caseation, alveolar abscess, periostitis (fractured jaw), and suppuration about tumours, *e.g.*, goîtres or epithelioma of œsophagus. The disease may also occur as a complication of typhoid and pyæmia (in one instance after parturition).

To illustrate the forminable character which an alveolar abscess may assume, the following case is cited from the *Lancet* of October 25th, 1879 :—

A married lady, aged 23, suckling a child six months' old, towards the end of August, had a severe attack of toothache from taking cold. It was attended with swelling of the right cheek; the swelling passed down towards the neck, which was painful on pressure. As the patient had several carious teeth, nothing serious was suspected. The symptoms, however, did not yield to treatment, but were rather aggravated. Then inflammation of the parotid was diagnosed. The neck was stiff and very painful; it was indurated as far as the clavicles; the skin was shiny and tense, of a reddish-brown colour, and very painful when touched. The pharynx and fauces could not be examined on account of the difficulty of opening the mouth. Swallowing was painful. The disease progressed during the next days. On September 5th, after an attack of coughing, she spat up a quantity of very stinking pus. On September 7th the patient complained of apnœa, and was troubled with cough. Pulse was small, and there was oppression over the heart. The patient went off in a dead faint, which lasted some time. On the following day the pain and oppression in the chest were increased. She died in the evening.

The autopsy revealed extensive sloughing of the cellular tissue of the neck, with implication of the muscles. The parotid and submaxillary glands were gangrenous; the skin over the right side of the neck was also gangrenous; a quantity of very fœtid ichor discharged itself after death. A communication was also found with the pharynx. The right lung was collapsed in great part, and the pleural cavity filled with a fœtid serum in which flocculi were abundantly present. The left lung was undergoing caseous degeneration; its pleural cavity contained a quantity of unaltered serum. The pericardium was adherent to the lungs, and reddened on its exterior aspect; it contained a pint of serolymphatic fluid. The surface of the heart was everywhere covered with a layer of granulations, six lines thick.

Another cause, not usually recognised, is, I believe, to be found in an acute septic perichondritis of cartilage, analogous to acute suppurative periostitis of bones. The following case is an example :—

William W., æt. 39, was admitted on April 2nd, 1891, under the care of Mr. Davies-Colley, for cellulitis of neck, the swelling lying under the lower jaw and extending from the right to the left sterno-mastoid. His illness was stated to have begun on the 28th of March, with a sore throat, and shortly afterwards a small swelling appeared on the neck. For the last four days he had scarcely been able to swallow any solid food. Mr. Colley made an incision along the anterior border of the left sterno-mastoid, and evacuated a large quantity of foul-smelling fluid. On the 4th, he sleeps badly. On 7th, an abscess noticed at the lower part of the back, which was opened next day. Foul-smelling pus and gas was evacuated. The patient sank on the 9th.

Post-mortem by Dr. Perry.—The parts of the neck were removed before I came into the post-mortem room. They were matted together by inflammation and œdematous, and on the left side there was a large area of necrosis affecting the thyroid cartilage, which was mostly stripped of perichondrium, and the great cornu of the hyoid bone on the left side was also necrotic and detached from the body of the bone. The cause of the necrosis was not evident, nor whether it was primary or secondary to a cellulitis that had been set up by some other cause. No such cause, however, was discovered. I could not learn whether the patient had had syphilis or not, and I am inclined to think that the case was one of acute suppurative perichondritis resembling an acute suppurative periostitis and septicæmic in origin. The interior of the larynx was perfectly normal, and the disease clearly had not started there. There was also found a chronic ulcer of stomach and duodenum, and the patient had membranous colitis. The breach of surface in the stomach may have afforded a mode of ingress to the specific organism.

As to *age*, the disease is commonest from childhood to middle life, but it may occur later. As a predisposing cause may be mentioned chronic alcoholism, as it appears that patients suffering from this disease have been for the most part addicted to drink.

Butchers also, whose occupation exposes them especially to septic inoculation, more often contract the disease than others. The following example may be quoted:—

A male, æt. 50, a butcher, was seized early in the morning with a severe rigor, dysphagia and great pain in the mouth and submaxillary region. Temperature a few hours later was 105, pulse 150, respiration noisy, due to swelling about the laryngeal orifice; headache, prostration, and cold sweat. Tongue pressed up against the palate by swollen sublingual tissues. Fauces could not be seen. Patient could neither swallow nor speak. Albuminuria to the extent of a sixth. Next day submaxillary œdema increased, with commencing redness of the skin, and spreading down the neck between the sterno-mastoids. Patient weaker and dyspnœa increasing. Incisions made in the middle line, one above the hyoid, and one over the cricoid. Tissues swollen, sodden and foul, and serous blood-stained fluid came out. Great immediate relief. No local condition, such as a carious tooth or ulcer of mouth, could be discovered.—*Lancet*, 1891, vol. I., p. 1258.

Many of the older writers, influenced by prevailing views of epidemic influences, described the disease as an epidemic, or at least as liable to occur in groups. This does not appear to be borne out by fact, but it is at least true that there are many cases of Ludwig's Angina, which have still to be regarded as idiopathic, meaning only by this term that we are unable to trace the manner in which the septic organism has gained access to the deep tissues of the neck.

It is possible, and indeed probable, that in certain inflammatory conditions of the upper respiratory and alimentary passages, organisms are able to go through the mucous membrane and so to reach the deeper parts.

It should be stated that the local manifestations of suppuration in the neck may be very insignificant, inasmuch as the mischief may be at first entirely beneath the deep cervical fascia, into the attachment of which I need not go in detail. From the arrangement of this fascia it follows that suppuration may make its way upwards beneath the floor of the mouth, backwards amongst the muscles of the neck, or downwards into the anterior and posterior mediastinum.

The chief symptoms of the disease are, or may be:—Fulness and tenderness in the neck—sometimes ill-marked and obscure, at others of an obviously phlegmonous character—sore throat and occasionally dysphagia.

A patient having the last-named symptom was some years ago under the care of the late Mr. Durham, and so marked was the difficulty in swallowing that he was suspected to be suffering from an aneurysm pressing on the œsophagus. However, at the post-mortem the cellular tissue of the neck was found to be infiltrated with pus. There is also often present dyspnœa, with quickened respiration. On examination of the mouth, nothing of importance may be seen. With the laryngoscope a little œdema of the epiglotis may be evident. In one instance an abscess was discovered opening between the epiglotis and tonsil.

Symptoms may also be present depending on the inflammation of nerve-trunks, the pneumogastric being most commonly implicated in the suppurative process. The pleura and pericardium may also be affected by inflammation, and may speedily be filled with purulent effusion.

The temperature is, as a rule, pyrexial, but in the case of those who die very rapidly, it may be little if at all raised.

Treatment.—Some success has been obtained by the injection by carbolic acid in solution, but there can be no doubt that in the present day, and especially in hospital practice, the right treatment is by surgical methods. An early incision should be made, either in the middle line of the neck, or along the anterior border of the sterno-mastoid. In the way of constitutional treatment it is well to support the patient's strength with nourishing food, which may be administered by a tube (if necessary), and stimulants will usually be indicated.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	1.	Mitral regurgitation and aortic stenosis.
	23.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
Philip	23.	Mitral and tricuspid regurgitation. Ascites.
	26	Mitral stenosis.
	28.	Mitral regurgitation.

Nervous System.

Mary	8.	Locomotor ataxy.
	9.	Cerebral tumour. Trephining.
	12.	Chorea.
	13.	Exophthalmic goître. Raynaud's disease.
	14.	Hysteria.
	22.	Plumbism. Wrist-drop. Optic neuritis. Tremors. Rigidity of legs.
	26.	Cerebellar tumour. Optic atrophy.
	29, 31.	Right hemiplegia.
	36.	Paraplegia. Mitral regurgitation.
Philip	11.	Sciatica.
Stephen	2.	Peripheral neuritis.
	5.	Ataxic paraplegia.
	22.	Cerebral syphilis.
	38.	Myelitis.

Alimentary System and Abdomen.

Mary	7.	? Gastric ulcer.
	32.	Jaundice.
	49.	Typhoid fever.
Philip	7.	Gastric ulcer.
	38.	Appendicitis.
Stephen	11.	Tuberculous peritonitis.

Genito-Urinary System.

Mary	20.	Renal calculus.
	38.	Acute nephritis.
	43.	Hæmaturia. ? Cause. Passage of polypoid masses. Pelvic tumour. (Girl æt. 2).
Philip	10.	Granular kidney. Hypertrophied heart. Plumbism. Gout. Epistaxis. Pleurisy. Anæmia.
	18.	Chronic tubal nephritis.
	24.	Hæmaturia.
	28.	Chronic nephritis. Dropsy.
Stephen	13.	Hæmaturia.
	16.	Diabetes mellitus. (Boy æt. 4).
	22.	Chronic tubal nephritis.
	33.	Acute nephritis.

Respiratory System.

Mary	11.	Tuberculous pleurisy.
	15.	Empyema.
	21.	? Phthisis. Bronchiectasis. Fibroid lung.
	27.	Diphtheria. Laryngeal.
	28.	Empyema.
	34.	Broncho-pneumonia.
	39, 41, 42.	Phthisis.
	55.	Diphtheria. Antitoxin rash.
Philip	5, 15.	Right pleurisy.
	9.	Phthisis.
	17, 32.	Broncho-pneumonia.
	22.	Mediastinal growth. Laryngeal paralysis.
	25.	Pleurisy. Bronchitis.
	26, 29.	Pneumonia.
	35.	Phthisis. Tuberculous laryngitis.
Stephen	3.	Phthisis. Tuberculous laryngitis.
	4, 10.	Pneumonia.
	17, 23, 35.	Phthisis.
	36.	Phthisis. Enlarged liver. ? Cirrhosis. ? Lardaceous.

Miscellaneous.

Mary	24.	Thrombosis of veins of leg.
	30.	Addison's disease.
	35.	Lupus vulgaris
	40.	Phlegmasia dolens
	45.	Eczema.
	51.	Hodgkin's disease.
Philip	13.	Psoriasis. Pain in side. ? Cause.
	31.	Plumbism.
	34.	Gout.
Stephen	1, 20.	Plumbism.
	7.	Urticaria.

Acute Rheumatism.

Mary	9, 17, 44, 48.
Philip	3.
Stephen	15.

CASE UNDER DR. GOODHART.

MARY.

A. B., æt. 23. Admitted for nervousness and palpitation of heart. Father died of heart disease. Sister suffers from chorea. Patient has suffered from palpitation for two years. Has been troubled with fainting fits. Patient states that last summer she noticed a choking sensation in the throat and a swelling over the thyroid region, which lasted three or four hours and then subsided. This condition has occurred several times. Patient suffers constantly from headache; and is a pale anæmic girl with marked exophalmos. Eyelids not retracted but drooping, and the movements are synchronous with those of the eye. Cardiac impulse in fifth space one inch internal to nipple. Blowing systolic murmur, best heard at apex and traceable downwards and outwards; also systolic murmur in aortic region. Marked supra-sternal and abdominal pulsation. Patient starts violently at the slightest noise. Since patient has been in the hospital she has developed Raynaud's disease, the fingers and toes going perfectly blue and cold in the morning, becoming better later in the day, and taking a curious pink tinge.

Diagnosis.—Exophthalmic goître. Mitral regurgitation. Raynaud's disease.

CASE UNDER DR. PERRY.

JOHN.

7. W. L., æt. 41., a barman. Admitted into hospital for first time, June 13th, 1894, under Dr. Pitt, for jaundice and enlarged liver. He had at one time been in the army, and gave a history of syphilis (a primary sore, but no secondaries). For fifteen years before admission he had been a barman, and had drunk four to six and sometimes 12 glasses of beer daily, with whiskey occasionally. Four weeks before admission he became jaundiced, with accompanying symptoms of itching, headache, coloured vision, etc. Previously he had all his life enjoyed good health.

On admission.—Patient was found to be deeply jaundiced, his liver enlarged, reaching within two inches of the umbilicus. The liver dulness commenced above, at the fifth rib, the distance between the upper limit of the dulness and the lower edge of the liver being eight inches. The liver was hard, smooth, and not tender. The fæces were absolutely colourless (clay-coloured). He was treated, and left the Hospital June 27th, much relieved. The fæces had become coloured, the urine contained no bile, and the itching had disappeared, the skin now showing only faint tinge of yellow. The liver was also thought to have markedly decreased in size. The case was diagnosed as hypertrophic cirrhosis of the liver.

After a short period of improvement, patient was again admitted into Stephen, under Dr. Taylor, on August 13th, with a similar attack of jaundice. The liver now reached to within two inches of umbilicus, while the distance from the upper limit of dulness to the lower edge of the liver increased seven and a half inches, the distance between the edge of the ribs and the lower edge of liver being four inches. The spleen could just be felt on deep respiration. He was now very deeply jaundiced. Patient stated that since the commencement of his illness he had lost three stone in weight. He did not, however, appear at all emaciated. His motions were colourless.

August 15th. A tense tumour was felt on right side below edge of liver, apparently being the distended gall-bladder. Dr. Perry saw patient at this time, and considered he was probably suffering from cirrhosis, but admitted the possibility of malignant disease or impacted gall-stone.

September 8th. Patient weighed 150 pounds.

10th. Dr. Taylor saw patient, and gave it as his opinion that his condition was due to malignant disease, possibly of the head of the pancreas or in some such similar situation, pressing on the common bile duct. He also discussed the cirrhosis view, but considered that the absence of bile in the fæces was decidedly against it, while against the diagnosis of impacted gall-stone was the absence of any previous history of pain or of attacks of colic.

18th. A few drops of blood were noticed in the motion.

29th. Liver was same size, but the jaundice was less than on admission, and motions were light yellow colour.

Patient was transferred to John ward October 2nd. Weight was 150 pounds. It was noted that it was possible by palpation to feel right down the vertebral column just below edge of liver, and no trace of any tumour could be found. A microscopical examination of fæces revealed nothing abnormal. October 9th, patient had a sharp attack of diarrhœa, which lasted till he was discharged. October 11th, patient's weight was still 150 pounds. The diagnosis at time of discharge was malignant disease, while as impacted gall-stone had been suggested, Mr. Symonds was asked to see the case, but considered an operation quite unnecessary.

Patient was admitted January 21st, 1895, into John, under Dr. Hale White, for jaundice and swelling of abdomen. He had remained in fair health since discharge till three weeks before re-admission, when he noticed his feet and abdomen swollen.

On admission.—Patient appeared to have wasted, his skin was of a very deep yellowish-green tinge. He had some internal piles. There was œdema of both legs and scrotum, and also some ascites. The liver was now felt three inches below ribs in axilla, four inches in nipple line, and one and a half below ensiform. The dulness commenced above at fifth rib. There was a definite sharp edge, and the notch between the lobes could be felt to right of ensiform. The distended gall-bladder could be felt almost the size of a Tangerine orange. There were two tender points along the edge, one to left of notch, the other in right flank. Spleen was not

palpable. Bowels open six or seven times daily, motions soft but brown-coloured (at times clay-coloured.)

January 28th. It was noticed the jaundice was less, but had left a general greenish discoloration of the skin.

30th. Patient had a good deal of pain from wind. There were now no tender points.

February 7th. Patient was noticed to be weaker, and the ascites had increased. The liver was now only three inches below the ribs, the dulness above commencing at fifth rib. There was some dulness at the bases of the lungs behind (probably fluid).

11th. Patient was tapped, and eleven pints of fluid removed from abdomen. After tapping, the liver was only two and a half inches below ribs, and the distended gall-bladder could be very distinctly felt. The surface was smooth. At this time Dr. Hale White was strongly of the opinion that patient was suffering from malignant disease. The points which he insisted on being that the jaundice was too deep and too greenish a colour for cirrhosis, that cases of cirrhosis when the acute symptoms had set in (ascites and jaundice) never lasted long, especially after tapping. He also laid stress on the facts that patient's motions were absolutely clay-coloured at times and that there was very considerable, if not complete, obstruction, as evidenced by the distended gall-bladder. The presence of tender spots on the liver also pointed to malignant disease. To account for the motions having become brown, he suggested that there might have been originally a gall-stone impacted, which had caused obstruction and then ulcerated through, the ulcer then becoming cancerous.

22nd. Patient was tapped again, fifteen pints being drawn off. Liver was now two inches below margin of ribs in nipple line, the edge being very hard and curved upwards.

Patient was again tapped on 4th March and 18th. Patient had now begun to complain of great pain. A rub was heard over the liver. Patient was under Dr. Goodhart, who made diagnosis of cirrhosis of liver.

April 1st, patient was tapped, and again on 13th. He was now suffering extreme pain, and had to be kept continually under morphia. The pain was chiefly in left hypochondriac region, and seemed due principally to flatulence. It was somewhat relieved by enema assa-fœtidæ. Resin of capaiba was ordered, to try and relieve the ascites, but patient could not take it, as it made him sick. His appetite became very bad, and patient was now very wasted. He did not vomit, except on two occasions. There was a tendency to constipation, which was best relieved by enemas. At one time some peristaltic movements were noticed over region of stomach. Patient's motions were dark coloured.

April 30th. Patient was again tapped, and again on May 4th. Patient was in an extreme condition, terribly wasted, and kept under continual influence of morphia, necessitated by the great pain. The liver now (May 4th) extended one and three-quarter inches below ribs in nipple line; it was not particularly tender and felt slightly nodular on surface. The edge at the right felt turned up; no lump could be felt in abdomen. The gall-bladder could be felt, but was rather flaccid. Patient gradually sank, and died on May 8th.

Patient was under Dr. Perry since April 1st, the diagnosis being cirrhosis of the liver, resting on the facts that patient had been a barman, and that the liver seemed to have definitely contracted.

At the autopsy the following was found:—Patient weighed 98 pounds. Liver was normal size, but weighed 96 ounces, studded all over with small nodules of growth varying from size of pea to that of walnut. In several cases they were caseous in centre, but there was no marked umbilication. A primary growth was found in the upper three inches of the duodenum, broken down and sloughing, presenting a shreddy surface. The whole circumference was involved except half an inch. There was no present obstruction. The bile duct opened into the middle of the growth and was greatly dilated (three inches in circumference). The pancreatic duct opened separately about half an inch from bile duct and was greatly dilated also. The terminal common portion of the ducts had been destroyed by breaking down of the growth. The gall-bladder was greatly dilated and hypertrophied; it contained normal bile and no stones; there was no present obstruction. The pancreas was not apparently invaded by growth, but was indurated, and ducts dilated from backward pressure. The bile ducts in the liver were not much dilated. There was slight amount of cirrhosis in liver, due to probably backward pressure. A large mass of glands infiltrated with growth surrounded the duodenum and pancreas. The growth spread around the aorta and on either side towards the kidneys, but did not infiltrate them. The right suprarenal capsule was infiltrated at its apex. There was thrombosis of the superior mesenteric vein and of many of the portal veins, one of the bronchi in the latter being infiltrated with growth. There was no peritonitis, but one or two nodules of secondary growth scattered throughout abdominal cavity in Douglas' pouch, while the peritoneum had a soddened appearance, as if from maceration in the ascitic fluid. On upper surface of liver to right side there was some recent inflammation, the liver being adherent to the diaphragm. The edge of the liver was blunt and nowhere turned up. There was some ulcerative colitis affecting the summits of the transverse folds of the mucous membrane of the first 18 inches of the colon.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ACCIDENT 12. T-shaped fracture of lower end of femur into knee-joint.

19. Ruptured urethra. Urethra torn completely across. Ends sewn together.

25. Fractured femur. Compound fracture radius and ulna.

NAAMAN 1. Genu valgum.
7. Recurrent epithelioma penis; amputation 3½ years ago.
10. Caries of cervical spine.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS 2. Compound fracture tibia and fibula.
12. Extra capsular fracture of neck of femur.
18. Cut on forearm. Cut flexor tendons.
LUKE 2. Acute necrosis.
10. Swelling about the lower end of arm. ? Syphilitic periostitis.
10. Swelling in inguinal region. ? Omental hernia.
12. Ruptured urethra; introduction of catheter.
16. Epithelioma of larynx.
20. Strangulated femoral hernia.
21. Acute abscess on tongue.
LYDIA 6. Swelling on back. ? Nævus.
6. Strangulated umbilical hernia.
18. Swollen elbow with large punched-out ulcer in girl of 12. ? Tubercular. ? Congenital syphilis.
18. Fractured neck of femur.
20. Fracture of both malleoli.

CASES UNDER MR. LUCAS.

JOB 5. Chronic enlargement of tibia. ? Syphilitic osteitis. Node on head. Some symptoms pointing to locomotor ataxy.
15. Periostitis of femur.
20. Hydrocele of tunica vaginalis.

CASES UNDER MR. SYMONDS.

MARTHA 13. Bronchocele. Enucleation of nodule.
14. Abdominal swelling. ? Ovarian cyst.
15. Syphilitic stricture of rectum. ? Colotomy.
SAMARITAN 8. Senile gangrene of foot; amputation above knee.

CASE UNDER MR. DUNN.

MARTHA 11. Chronic arthritis deformans following an injury.

Nursing News.

Nurses Wilson and Marler, of Guy's Institution, successfully passed their L.O.S. Examination on April 24th. They received their training in the Guy's Lying-In Charity.

Miss Fanny P. Davis has been appointed Night Superintendent of the Metropolitan Hospital, and has already entered on her duties. Miss Davis has worked for four years in the Hospital for Sick Children, Myrtle Street, Liverpool, and for one year as lady pupil in Guy's Hospital. We wish her every success in her new work.

Chapel News.

FLOWERS for the Chapel vases are always most welcome gifts, and those of our students who have the good fortune to dwell in the suburbs might sometimes replenish our stock out of the gardens they possess or have access to. The offertory fund enables us to purchase some every Saturday. On or about the Wednesday following, Sister Cornelius is glad to be able to replace any faded flowers with such fresh ones as may be given her. Failing such gifts, we have to put up with the faded ones, or go without.

Why is it that there are no men in the choir? We have never been able to find a satisfactory answer to that question, considering how many men are in various ways connected with this Hospital. Seven or eight years ago there were four tenors, one bass, and one alto, amongst whom £36 *per annum* was distributed—out of the Chaplain's private purse! Having some slight acquaintance with harmony and with business, the present Chaplain came deliberately to the conclusion that the arrangement was, in more ways than one, discordant with his feelings, so twelve months after he came into office he fell back upon a choir of boys. The work has, on the whole, been satisfactorily done. We have no fault to find. But the world's stock of unison music is small and our singing is capable of improvement—just the improvement that six or eight men would effect. The needful cassocks and surplices are in the Vestry. There is a sufficient supply of books. We want volunteers—men who can read music at sight, if we can get them: but, above all, men who come to stay as long as possible, for nothing so spoils the efficiency of a choir as frequent changes in its *personnel*. If the junior men would only take the hint!

Everything comes to him that waits. We may, therefore, confidently predict that some day we shall see the vacant spaces in our reredos filled in with pictures, for we are still waiting. There was a month in which it seemed likely that a distinguished Royal Academician would take pity on our emptiness; but, alas! our hopes vanished one morning when a polite note reached us informing us that we need hope no longer. We are still open to receive offers of paintings, and, since a little over £10 remains to be paid for the oak-work, subscriptions towards the Reredos Fund are still acceptable to the Counting-house officials.

One piece of news to finish with. We think that the only one distinguished Churchman ever connected with Guy's was Frederick Denison Maurice. His name is known all over the theological world, and his opinions and works are still much valued and quoted, especially in the States. He was Chaplain of Guy's from 1836 to 1846, yet there is not so much as a single memento of the fact about the place, and even the pulpit from which he preached his Boyle and other lectures lies in ruins in a cellar underneath Hunt's house.

From the Gazette's Special Pathologist.

All specimens — particularly those of solid tissues — should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

H. H., Eastbourne.—The tumour is due to lobular induration of the breast tissue. There is much inflammatory formation around the larger ducts. No indications of malignant disease.

W., Middlesborough.—Tubercle bacilli are present in the sputum in large numbers.

G. S., Bloxham.—No tubercle bacilli could be found in the sputum.

J. M. O., Fishguard.—A few tubercle bacilli are present in the sputum.

C. H., Guy's.—Tubercle bacilli are present in fairly large numbers.

J. A. B., Bromsgrove.—No tubercle bacilli could be found in the sputum.

C. J. G., Bancroft.—A few tubercle bacilli are present in the sputum.

PATHOLOGIST.

The College Library.

From the Librarian's report, which has just come to hand, we find that the number of volumes borrowed during the past year, from May, 1894, to April, 1895, is 909. The favourite author appears to be Kipling, whose works were borrowed 68 times ; Stevenson comes next with 65 ; Badminton, on Sport, 33 ; works by Q., 29 ; Hardy, 17 ; Besant, 17 ; Wendell Holmes, 15 ; Meredith, 13 ; Kingsley, 12 ; Bret Harte, 12 ; Zola, 12 ; etc. Thirty-seven volumes were borrowed from Mudie's, which were in turn borrowed 225 times. Hall Caine heads the list with The Bondsman, and The Manxman, 33 times ; Esther Waters, 29 ; The Yellow Aster, 18 ; works by Sarah Grand, 21 ; and the works of Conan Doyle and Stanley Weyman are still being extensively read. The number of volumes borrowed by the Nurses is 343, making a total during the year of 1,252 volumes.

Printed copies of the library catalogue in book form can still be had of the Librarian, price 4d.

Appointments.

Mr. Lane has been appointed Lecturer on Anatomy, *vice* Mr. Jacobson resigned.

Mr. Dunn has been appointed Teacher of Operative Surgery, *vice* Mr. Symonds resigned.

It is understood that Mr. Dunn will continue to take charge of the Revision Classes in Surgery.

By Mr. Lane's promotion, the Demonstratorship on Practical Surgery and on Morbid Histology (Surgical part) becomes vacant, and for this post applications are invited before the last day of the month.

Several other posts upon the Junior Staff become vacant next October, of which particulars are given below.

Clark, A. W., L.R.C.P. Lond., M.R.C.S., has been reappointed Honorary Medical Officer to the North Cambridgeshire Cottage Hospital.

Collis, A. J., M.A., M.B. Cantab., M.R.C.S., L.R.C.P., has been appointed Resident Medical Officer at the Weston-super-Mare Hospital and Dispensary.

Dalton, A. J., L.R.C.P. Lond., M.R.C.S., has been reappointed Medical Officer for the Hundred Sanitary District of the Wantage Union.

Ensar, H. C., M.R.C.S. Eng., L.S.A., has been appointed Honorary Ophthalmic Surgeon to the Newport and Monmouthshire Infirmary.

Vacant Appointments.

The following vacancies for next October are announced :—

A Demonstratorship of Practical Surgery and Morbid Histology.
Two Demonstratorships of Anatomy.
A Demonstratorship of Physiology.
A Demonstratorship of Biology.
A Demonstratorship of Chemistry and Physics.
A Medical Registrarship.
A Surgical Registrarship.

Gentlemen appointed to any of the above vacancies will be required to begin their duties on the 1st of October next. Further particulars may be obtained from the Dean. Applications must be sent to the Treasurer, the Counting House, Guy's Hospital, S.E., on or before Friday, May 31st, 1895.

L. E. SHAW, Dean.

May 21st, 1895.

Passim.

The "Ladies' Night" of the Debating Society will take place to-day, in the Smoking-room, at 7.30 p.m. Dr. Pavy, the President, has kindly promised to take the chair. Mr. L. A. Parry will propose—"That this House upholds the advantages of a Scientific over a Classical Education." Mr. Hamblin Smith will lead the opposition. Refreshments will be provided in the Dining-hall.

The Master of the Salters' Company has kindly consented to distribute the prizes and certificates to successful students on Speech Day, which is announced to take place on Wednesday, July 3rd.

The following Prize Examinations are announced to take place shortly. The Treasurer's Gold Medals, from June 5th to 8th; the Sands Cox Scholarship, June 5th to 7th; the Fourth and Third Years' Students, June 11th to 15th, and for the Second and First Years' Students, July 17th and 18th. For further information, intending competitors are directed to the notices in Colonnade, and names must be left at the Medical School Office two clear days before the commencement of the examination.

There are two vacancies for the post of Assistant Demonstrator of Anatomy for the next Winter Session. Assistant Demonstrators are appointed from among the Students to give "special instruction in Elementary Anatomy" to the Students in the Dissecting-room, and hold office for one Winter Session.

"A Bill intituled an Act to make further provision with respect to the University of London" has been introduced into the House of Lords by Lord Playfair. The Bill asks for powers to appoint Commissioners with respect to the reconstitution of the University of London, as to the duration and proceedings of Commissioners, and as to the powers and duties of Commissioners.

It is asked that the powers of the Commissioners shall continue until the end of 1896, that they shall make statutes and ordinances for the University of London in general accordance with the scheme of recommendation recently adopted, "but subject to any modification which may appear to them expedient after considering any representations made to them by the Senate or Convocation" of the University, or "by any other body or bodies interested." The interests of non-collegiate students are to be adequately provided for, and "all such statutes and ordinances" shall come into operation on the expiration of forty days after they have been laid before both Houses of Parliament.

Candidates for the Examinations for Medical and Surgical Degrees at the University of Cambridge, are reminded that several important alterations have been made in the time and place of the oncoming First and Second Examinations, of which information may be obtained in the Medical Office.

The Pass List at the recent L.D.S. Examination is satisfactory, there being four failures out of fifteen candidates from Guy's. We have been asked to remind those of our Dental Students who intend to enter themselves as candidates for the November Examination not to allow the above result to make them over confident.

A Bazaar on behalf of the restoration of the Church of Allhallows Barking, E.C., will be held by kind permission of Lord and Lady Brassey in the Museum at 24, Park Lane, on Thursday and Friday, the 30th and 31st instant. Guy's are indebted to this—the oldest parish church in London, inasmuch as the chaplain to the laundry hostel is one of the clergy of the Allhallows' Parish. Moreover, additional interest is lent to the occasion as the Matron, assisted, we understand, by the lady pupils of Guy's Hospital, is to be a stallholder. The bazaar will be open on the 30th from 3 to 6 p.m., admission 2s. 6d.; on the 31st from 11 a.m. to 9 p.m., admission 2s. 6d. till 6 o'clock; 1s. after that time.

The Magazine of the London School of Medicine for Women and Royal Free Hospital—No. 1 of which we received recently—is an elegant if somewhat bulky volume of forty pages. Our contemporary has taken for its motto: "Work is as it is done," and the Editorial Committee are to be heartily congratulated on the success of their first effort. For the clinical material we have nothing to say but that it is well chosen and very suitable to a student's

journal. There is an unmistakeable feminine character about the contributions dealing with Hospital and School News. We can assure our readers that the "Magazine" is well worth studying. We only wish we had such willing contributors as it seems their lot to possess.

On Ascension Day (Thursday last) the ancient custom of what is known as "Beating of the Bounds" was performed in the parish of St. Olave's, Southwark. The parish officials, headed by their two beadles in gorgeous apparel, and a small army of Borough boys, each of whom bore and switched, to the common danger, long canes, went the round of the boundary stones. As the boundary line passes through part of the Hospital grounds, when the "beating" party arrived to do its work, they were followed with interest and amusement by the large crowd assembled in the park. The "Beating of the Bounds" takes place every seven years in the St. Olave's parish, though once upon a time it was an annual function, and was more thoroughly and seriously carried out.

We have received from Mr. Joseph Parsons a letter acknowledging the receipt of his testimonial, in which he says: "Will you render my sincere thanks to all for their kindness, for which I am very thankful? I am glad to say I am improving in health, but very slowly."

Dr. Marcet will deliver the Croonian Lectures, on "Contribution to the History of the Respiration of Man," at the College, Pall Mall East, on the following Tuesdays and Thursdays, June 18th, 20th, 25th, and 27th, at five o'clock.

Pass List.

Royal College of Surgeons of England, May, 1895.

First Examination for the Fellowship.

Evans, Evan.	O'Meara, E. J.
Fremantle, F. E.	Spicer, A. H.

Examination for the License in Dental Surgery.
(Unofficial List.)

Bowden, G. H.	Morgan, E.
Cahill, A.	Mühlenkamp, F.
Collett, A. J.	Stevens, D. S.
Cook, H.	Taylor, H. P.
Keall, C. A. H.	Trick, W. H.
Wallis, H.	

In Memoriam.

Arthur Edward Durham.

1834—1895.

Arthur Edward Durham was born at Northampton in 1834, and entered at Guy's in 1855. He passed the first M.B. examination in 1857, taking honours on the occasion as he had done at the Matriculation in 1854; the M.R.C.S. examination in 1858, and that for F.R.C.S. in 1860. Already in 1859 he had been appointed Demonstrator of Anatomy, and Lecturer on Experimental Philosophy and the Use of the Microscope at Guy's. On the promotion of Mr. Alfred Poland to the full Staff in 1862, Mr. Durham was appointed Assistant Surgeon, and became full Surgeon in 1873, a post he filled until his retirement last year, when he was elected a Consulting Surgeon. His lectures on Anatomy and Surgery will be remembered by numbers of old pupils.

In order to stimulate the practical study of anatomy he originated the "Arthur Durham Prizes for Dissection." Up to the time of his death he was Consulting Surgeon to the Royal Hospital for Women and Children, to the Stockwell Orphanage and the St. Alban's Dispensary.

He had served on the Council of the Royal College of Surgeons of England for many years, of which Body he had also been a Vice-President. After fulfilling the duties of Examiner for the College, he became Chairman of the Examining Board. He was also prominently connected with the Medical Society, Royal Medical and Chirurgical Society, Clinical Society, and others. This year he was to have delivered the Annual Address in Surgery, as President of that Section of B.M.A. The subject he had selected for his address—Preventive Surgery, or the Surgery of the Future—was one which could only be attacked by so original a mind and in a manner which, without his eloquence, would have been of no ordinary interest.

When the writer of these lines first met Mr. Durham, it was as demonstrator teaching the anatomy of the sphenoid bone, and the way to hold a scalpel in dissecting an uninjected upper extremity. As a student he must have been brilliant, and was appointed Demonstrator of Anatomy when he had only half completed his university course, a loss which he often regretted afterwards. As a demonstrator he was popular, enthusiastic, indefatigable, and a beautiful dissector. He

was already an excellent surgeon, and taught surgical anatomy by preference. At one time he was trying the effects of pistol shots on the outer and inner tables of the skull; at another, buying up the dissections of an entire body, and taking it up to show transposition of the viscera at a society; at another, showing us how to see the circulation in a frog's web. Maunder (who soon after left to be surgeon to the London Hospital), and Walter Moxon were his colleagues. Moxon was a more minute, perhaps a more accurate anatomist, less effusive, less popular, but diversifying his demonstrations to men reading for the first M.B. examination with metaphysical arguments, quotations from Marcus Aurelius, and a vein of Irish wit. Both were admirable men.

Soon after the writer quitted the dissecting-room, Durham became Assistant-Surgeon. He was a favourite of Mr. Hilton—then our leading Surgeon—and helped and was helped by him in many ways. They were a great contrast—the younger man tall and thin, with long graceful fingers, ready smile and eager confidence; the elder short and stout, with short, clumsy fingers, rather sardonic humour, and keen satire, and yet with the power of so impressing young men that they would go through any toil to earn his praise. After Hilton's death other vacancies occurred which made Durham full surgeon before he was forty years of age—full surgeon to Guy's Hospital.

We all know what use he made of this great opportunity—what an admirable operator he became, how shrewd in diagnosis, how ingenious in contrivance, how bold in action, yet how sagacious in judgment; how he built up a great reputation in public and private practice, at home and abroad; and how, with all his skill and success, his busy life and constant cares, he was never too much occupied to give a word to a friend: never too engrossed in the case as to forget the patient.

How much more he might have achieved can only be guessed by those who know under what disadvantages he did most of his work. Early afflicted with a degree of deafness, which increased as years went on, with frequently recurring gastric attacks which prostrated him for a time; and for the last seven or eight years of his life the subject of chronic bronchitis with emphysema, it was wonderful with what alacrity he recovered after each illness, working skilfully when more fit to be a patient himself, and never soured or ill-tempered by the trials that affect many of us the most.

Liberal, open-handed, and open-hearted, hospitable and generous, Durham had the reward he deserved. He was liked by all who knew him, and beloved by those who knew him well. He had a helpful hand and a pleasant smile for everyone, and everyone mourned his loss—*quippe benignus erat*. He was the friend of successive generations of students, and the idol of those who worked under him. He enjoyed his life—the labour and the play—the hospital wards and the travels to America and Norway. He had his sorrows: the death of his eldest son, whom many present Guy's men will remember, was a heavy blow; but while, like most men, there was room for regret, there was also room for thankfulness. This at least was worth living for—to leave the well-earned title behind him of the kindest of men.

The following letter from the pen of Dr. Wilks appeared in the *British Medical Journal* of May 11th last:—

The shock caused by the death of one of my dearest friends prevents me from calmly inditing any lengthy letter on his professional career. The most prominent features of his character are those which present themselves before me—namely, his ardent temperament, his strong sympathetic nature, and his kindness of heart; these were sufficient to make him a universal favourite; they created a response in others of a like kind, who ever spoke in the most enthusiastic manner of their love for Durham.

When he entered the Hospital as a student, he was at once marked out as a noticeable personage from the enthusiasm and energy which he displayed in all his work. At this early period he showed his aptitude for scientific studies, for it is now thirty-five years ago since he made his memorable experiments indicative of the state of the circulation in the brain during waking and sleeping. He demonstrated to the eye the conditions which are now universally taught as true—namely, the increased or lessened circulation in the brain in connection with its active or dormant state. He also demonstrated some doubtful points associated with moveable kidney, and was one of the first in this country to use the laryngoscope and to practise delicate surgery within the larynx itself. Since this early period Durham has published numerous papers more purely of a surgical nature. He was a remarkably good operator, not so much by evincing skill with the knife as by his delicate manipulation in

cases requiring the removal of foreign bodies, the use of the cautery, and such like procedures.

Good surgeon, however, as he was, he was most remarkable from his personal character; the enthusiasm he displayed in his work and the devotion he paid to every case which came before him was extraordinary. There was no shirking his duty; he did his best for everybody, giving no thought to money considerations; his only object was to relieve his patient. All this was done in the purest spirit, without a thought of reward, for he never bargained with a patient, but did his best for all alike; from those with scanty income he never received his recompense—thus the amount of work for which he was never remunerated must have been immense. It made no difference to him whether the patient was a poor clergyman or a needy actress from whom he never received a fee. All this was done out of the kindest and purest motives, so that it seemed as if doing good to others was the prime motive of his life. Never has an unkind act of Durham's reached the ear, seeing such a thing was impossible.

I have always thought of Durham when reading Wendell Holmes' description of the surgeon in *Elsie Venner*. He says, "I have heard it said that the art of healing makes men hard-hearted and indifferent to human suffering. While I am writing this paragraph, I catch a glimpse, as he rides by, of the manly features of a surgeon of skill and standing—so friendly, so modest, so tender-hearted in all his ways, that if he had not approved himself at once adroit and firm, one would have said that he was too kindly a nature to be the minister of pain, even if it were saving pain. You may be sure that some men, even amongst those who have chosen the task of pruning their fellow-creatures, grow more and more thoughtful and truly compassionate in the midst of their cruel experience. They become less nervous, but more sympathetic. They have a truer sensibility of others' pain the more they study pain and disease by the light of science."

It may well be supposed how beloved Durham was by his pupils, and how popular he was at the Hospital. He not only interested himself in the students' medical career, but associated himself with their clubs and recreations. No language was felt too strong to express the affection which they had for their teacher. Unfortunately his health was delicate, and at times he suffered much from depression; but when he last year took his Norway holiday to the high latitudes, and was braced by the northern air, his enthusiasm knew no bounds, and he became the most popular man on board. He had also been much affected by the loss of his son, who promised much in following his father's footsteps. He was the eldest of a most talented family. His loss will create a void in the circle of his friends which will never be again filled.

Vote of Sympathy by the Students' Club.

A Special General Meeting of the members of the Students' Club was held in the Anatomical Theatre on the 14th instant, Dr. Hale White in the chair.

Mr. Alfred Allport having referred to Mr. Durham's inseparable connection with the Students' Club, said: It is not for me to tell you what you all know, that his reputation as a surgeon was world-wide—that as a teacher he stood alone—but what I will say here is, that he was a simple, true gentleman. His was the kindliest heart which ever beat, he could not live without doing good. It seems only a week or two ago that we met in this room to give him on his retirement a little present as a testimony of our affection, and never will any of us forget how he rose, and looking round on the crowd of faces, his kindly eyes filled with tears as he said, "My boys, I thank you from the bottom of my heart." An oration could not have touched us more than those words. We were all his boys, and he took the kindliest interest and delight in every one of us—not merely praising the good, but helping those who were off the path as well. May God send many such men across our paths, for there are none better. I have the sad privilege to propose—"That we, the members of the Guy's Hospital Students' Club, do pass a vote of heartfelt sympathy with Mrs. Durham and family at the irreparable loss of our President and best friend."

Mr. H. J. Spon, in seconding, said: It is just six weeks ago that we met our late President. On that occasion I had the honour to propose a vote of thanks to him. Little did any of us think that that was the last time we should have the opportunity of thanking him, and little did I foresee what was to be my next duty towards Mr. Durham. We all know what he has been to us as a club, but perhaps we hardly realise that to him we owe its very existence. He recognised the want of such an institution, and from the very first when he put his heart into the work he always insisted upon the great benefits arising from it, and I am confident he himself would desire no better tribute to his memory from us than that we should maintain and increase the high position and good work of the Students' Club. On the last occasion when he spoke to us, reference was made to the portraits of some members of the Staff which had been recently presented to the Club. He then promised to supply us with a better one of himself; now it is too late to receive this from his hands. But

all of us will agree that we should perpetuate his memory in some lasting form, and I would suggest that we should subscribe to have his portrait painted, if possible, and hung in our own Club. I would like further to say that while we here to-day, in passing this vote, wish to express to Mrs. Durham and the family our deep sympathy with them in their great sorrow, we would also desire to convey to them our admiration for the brilliant genius which made our late President a surgeon among surgeons — our appreciation of that unselfish spirit which placed Guy's Hospital first and foremost throughout his career, and our imperishable recollection of that kindliness of heart which made Arthur Edward Durham beloved by his fellow-men.

The vote having been passed unanimously and in silence, the meeting separated.

In a letter to Dr. Fawcett, acknowledging the vote, Mr. Herbert Durham says:—"We all know and appreciate what he and Guy's were mutually to each other. The recollection of last year and its mixed grief and joy felt by all at their nominal parting, comes vividly before us. My mother, my uncle, and all of us, must just ask you to tell how much we appreciate the kind sympathy that we know is deep and true in the voice of Guy's men, and that it is from their hearts. We know what you all feel, and thank you all sincerely—most sincerely."

Introductory Lecture to the Course on Materia Medica and Therapeutics.

DELIVERED AT GUY'S HOSPITAL, MAY 5TH, 1874,
BY W. MOXON, M.D., F.R.C.P.,
Physician to the Hospital.

(*Continued*).

Now, if by therapeutics you mean the composing of potions and pills, why I think that is rather a poor, mean sort of thing. No doubt, the amount of good you do by a potion or pill is often very questionable; so much so, that the science of potions and pills is not a very attractive science. But we must learn to regard the drug-medicine as no more than one branch of therapeutics: sometimes the fruitful, the necessary branch; often very small in its relative importance in the proper system of managing the patient. Pereira defines therapeutics as "that branch of medicine which has for its object the treatment of diseases." He says: "In the most extended sense of the word, it embraces all the known means of cure," and he adopts that sense. Mind, I am not saying anything against potions and pills; but I should not be doing my duty here as I wish to do it if I began to describe drugs to you without first clearly pointing out that the giving of physic does not constitute therapeutics. You will find that the drugs a good doctor gives are often only, as it were, signs and symbols in the plan he is carrying out for the patient's benefit—symbols vitally important in the practical world. Without the doses three times a day, the service would not go on. They unite the attention and work of doctor, patient, nurse, and friends in a periodic series of efforts, something not unlike those little yells a group of sailors make in time when they are hauling hard on a cable, without which it appears the cable would never come along, though there is no apparent force in the noises they make. Only here the patient has the dosing to himself; but then it is for his benefit; that potion every three or four hours is like a set of stepping-stones for his faith in the weary time. I am now speaking of the lowest degree of usefulness which potions possess; but they always can further play mighty sparkling little tricks with the heart, or brain, or stomach, so as to allow the doctor to share with nurse and patient a sense of the good that is being done by them all in their periodical concert. To obtain a correct view of the service rendered by drugs in the general effort that surrounds a sick person, is an essential step towards becoming a good useful medical man. They are quite indispensable. A doctor without physic is like a priest without a creed, or a poet without rhyme. It is only the other day that *The Times* said: "If there be anything which nature abhors, it is a doctor without medicine or advice." Medicine first, you see. I say, the mixture and the pill are often symbolic in reality, so that there is danger of your settling your faith upon such symbols to the neglect of essential means of aid. When asked to see some person who is drinking a great deal too much wine and brandy, or who eats too much, or spends too much time in study, or has engaged in more speculation than is good for his pocket and brains, what a figure you cut if all you prescribe is some drug three times a day! The true art in such a case consists in arranging the plan, including the medicine, so as to make the drinker drink less, the glutton eat less, the overworker work less. The profession of medicine will give you a great power in doing this; and, although no one can tell how much the drugs may do in their mysterious line, anyone can see the good effect of good advice with the aid of drugs. It is an ultimate fact in human nature that, if you do not give drugs, you will not be trusted to give the other advice. Do not make any mistake about this. If you try to get on without giving physic, you will be like those misguided thinkers on religious matters who hope to spread religion without a creed. It is very sublime, and suits your inside nature so well, that you try it on your friends. But it does not suit them. The reason need not escape you, if you remember that, inside, where the ideas grow, you are yourself; but outside, where you try to implant them, you are another, and not yourself; and that makes, literally, no end of a difference. You will be a wise man when you find out how you never are the same where you are another as where you are yourself. That is to see ourselves as others see us.

You may think there is nothing of modern discovery in all this; and, indeed, the most ancient doctors on record had a very clear notion of the necessity of considering circumspectly and in a comprehensive way the

causes and the management of their patients' disorders. So that they are worth more of our attention than they can receive from us in this busy time. This time, that is too busy to learn Greek, and proud of its flourishing present, seems ready to forget that whatever is good in the past is a trust we hold for the future. It is not only from the ancient physicians themselves that we know they were sensible doctors; indeed, physicians have always had an unfortunate way of leaving the most useful part of their advice out of their writings, and filling these with technicalities and trash more or less obscure. The ancient doctors wrote for people who understood all about the everyday affairs of the period. Unfortunately, they did not undertake to act the part of ancients at all; they thought they were working for a bright future, not a dusky remote past, in which the habits of life and common conversation of the people they lived amongst would be forgotten and become legendary, so that anything could be said and believed about them, and they would hardly get credit for knowing the obvious. Hence you find in the ancient medical writers too much about boluses and potions, perhaps, and too little of that quiet common sense advice they gave their real patients, which must have been good advice very long ago. The doctors who treated such men as Xenophon and Plato could not have been fools as a class. Of course, then, as now, there would be a great many fools among them. But the physician who felt the pulse of Pericles or Socrates could not but be a good man. You need not read Hippocrates's writings to know that he was a man of sound clear sense, for he was the principal physician of an age when the human intellect flourished as, perhaps, it has never flourished since. But his writings abundantly prove that he was a truly great physician, worthy of the noble age he lived in; entirely free from superstition; hating quackery; liberal in his teaching; so that we find him saying, "Try to do good, or at least no harm"; telling his pupils that life is short, and art long, and experience fallacious; directing their faculties to practical usefulness as skilfully as his contemporary Plato did to subtle and searching examination of the principles of personal and social goodness. It seems marvellous that, when he only wanted to infuse his honest simplicity into others, those in after generations should have taken him by force and made him an authority, and tortured his words into nonsense, having no heart for the spirit of them. It is not, however, only in their writings that we can form a knowledge of the physicians of that age; the lay writers of the time show us how much like doctoring London society was doctoring Athenian society. Let me read you such a piece as I will extract from Professor Jowett's charming translation of Plato in the *Republic*. Socrates is speaking thus with Adeimantus:

"You would compare them, I said, to those invalids who, having no self-restraint, will not leave off their habits of intemperance.

"Exactly.

"Yes, I said, and how charming those people are! They are always doctoring, and increasing, and complicating their disorders, fancying they will be cured by some nostrum which somebody advises them to try; never getting better, but rather growing worse.

"That is often the case, he said, with invalids such as you describe.

"Yes, I replied; they have a charming way of going on, and the charming thing is, that they deem him their worst enemy who tells them the truth, which is simply that, unless they give up eating and drinking, and lusting and sleeping, neither drug, nor cautery, nor spell, nor amulet, nor anything, will be of any avail.

"Charming! he replied. I see nothing charming in going into a passion with a man who tells you what is good.

"These gentlemen, I said, do not seem to be in your good graces."

That might have come from a fashionable novel of this day; only it is, perhaps, too like real life, and too sternly meant. Here we have the man doctoring himself, with a fool for patient. The public say a man that doctors himself always has a fool for the patient. And this truth goes farther than they think when they seem to infer that, if a man be doctoring anybody else, he has not a fool for his patient. That assumption is not justified, as Plato's very modern sort of instance proves well enough. It appears that the patient had got good sound advice, perhaps from Hippocrates, but determines to do as he likes, and goes about choosing whose advice he will to please him, really prescribing his particular doctor to himself as he before prescribed a particular pill. The same you will find largely done now. Invalids of the kind still keep the fool under their care, applying one and another pleasing doctor among the rest of their means of helping their foolish selves down the easy descent. When society was so like what society is now, the medical care of individuals would involve the same problems as those of our own time. And, indeed, you will find that there is a great deal to be learnt from Hippocrates. Not that I recommend you to spend your time in prolonged study of Hippocrates. It is of no use going back and trying to realise the teachings of the good men of all past time. There were so many, and past time is so long, you must leave off somewhere, especially when you find that the good men of former times thought much the same as yourself, were clear about the same plain truths, and stuck in the same muddles. You then find a repetition of your own notes much the same as when in music you come to an octave; this, you know, satisfies the ear, and anything beyond is the same over again. We have two such octaves in the history of medicine: one in the climax of Roman civilisation, and the other at the climax of Greek civilisation; the first marked by Galen and Celsus, and the second by Hippocrates and Asclepiades. At each of these times, we find a state of medical thought as like that of our own time as the crest of one wave to the crest of another coming on after it. But, just as in the

octaves of music, you have between the key-notes a lot of half-notes and queer discords, so in the intermediate times between the pure tone of Imperial Rome and the pure tone of this century there were very pitiful miserable howlings; all through those very properly so-called dark ages, wherein human nature crept in a loathsome slough of superstition; it is painful to take up any medical writing of those times; there may be exceptions, but the general result is almost to make you thank God that, as Hippocrates says, time is short, lest otherwise you should have had to wallow through the extended mire of an art which is so long and so dirty. Lest you should think I would impose upon you with fallaciously hard adjectives, I will read you parts of a prescription or two. The blood of a he-goat, taken from him in gelding him, and dried in the sun or an oven. The shavings of a boar's tooth. Horse-dung dissolved in carduus water and strained. White hen-dung given to a drachm of the same. All these, and others too nasty to mention, are from one column of Dr. Salmon's *Synopsis Medicinæ*, date 1681. They are for pleurisy. They are such prescriptions as are commonly found about that period and even much later.

(To be continued.)

Reviews.

The Surgical Diseases of Children and their Treatment by Modern Methods. By D'Arcy Power, M.A., M.B. Oxon., F.R.C.S., Demonstrator of Operative Surgery at St. Bartholomew's Hospital; Surgeon to the Victoria Hospital for Children, Chelsea. (London, H. K. Lewis.) Price 10s. 6d.

Clearly written, well illustrated, and excellently printed, this book will be warmly welcomed by all surgeons whose practice lies amongst children. Mr. D'Arcy Power has succeeded not only in conveying much information which is not found in any of the ordinary text-books of surgery, but of clothing it in language which makes the reading of the book a real pleasure. The chapters upon Tuberculous Diseases of Bones and Joints are especially valuable, and we are glad to see that Mr. Power consistently uses the word tuberculous to describe diseases which are caused by tubercle bacilli, instead of the vague and confusing word tubercular. In the chapter upon Surgical Diseases of the Air Passages the author gives a very clear summary of the advantages, in suitable cases, of intubation over tracheotomy. The last chapter, dealing with "Some Malformations and Congenital Deformities," might with advantage, perhaps, be considerably extended, but so interesting are many of the problems involved in the pathology and treatment of deformities and malformations, that if it were fully treated the volume would have to be very considerably increased in size.

A Manual of Gynæcological Practice for Students and Practitioners. By Dr. A. Dührssen, Privat Docent in Midwifery and Gynæcology in the University of Berlin. Translated and edited by John W. Taylor, F.R.C.S., and Frederick Edge, M.D. Lond., M.R.C.P., F.R.C.S. (London, H. K. Lewis). Price 6s.

It has been said that the only way to translate a German book into readable English is to read the original first, and then to write the translation without further reference to the text. The translators of Dr. Dührssen's excellent manual have, however, rendered it into English with painful accuracy; so much is this the case that one has frequently to recast whole sentences into modern English before one can be quite sure that one has correctly grasped their meaning. Except for this serious defect Dr. Edge and Dr. Taylor are to be congratulated on having placed in the hands of English students a book which well repays perusal, especially if it be read in conjunction with one of the standard English text-books upon the subject.

Dissections Illustrated: a Graphic Handbook for Students of Human Anatomy. By C. Gordon Brodie, F.R.C.S., late Senior Demonstrator of Anatomy, Middlesex Hospital Medical School. With Plates, drawn and lithographed by Percy Highley. (Whittaker & Co., London and New York.) Price 10s.

This, the fourth and concluding volume of Mr. Brodie's valuable work, well maintains the reputation of the previous volumes. Good plates of the abdomen, such as those in the part before us, are of especial value, from the fact that it is very difficult in the dead subject to obtain by dissection any clear notion of the appearance of the parts during life. The complete works contain no less than 73 coloured plates and 37 diagrams, and forms a complete atlas of the more important dissections of the human body.

Sport.

Cricket.

GUY'S HOSPITAL v. SURBITON.

PLAYED at Surbiton on May 11th. Guy's lost the toss and Surbiton went in. The innings is not worthy of much mention, as on a good, though slowish wicket, the home team were only able to get 119. Castle and Forsyth both played good cricket. Perks and Featherstone began the innings for Guy's, and our chance seemed a good one, as they both appeared at home with the bowling, though playing very carefully. Featherstone went at 30, and Perks was caught in the slips soon after, and then a most unaccountable rot, considering the wicket and bowling, set in, wicket after wicket falling, and the whole side being dismissed for the paltry total of 43. It is evident that the new men in the team this year must gain more confidence, both in themselves and the team as a whole, if we wish to win our matches.

Scores:—

GUY'S.

1ST INNINGS.		2ND INNINGS.	
A. Perks, c Baily, b Pinkerton	17	c Newton, b Baily	34
F. Featherstone, b Baily	7	b Baily	8
R. T. Fitz-Hugh, c Fielding, b Pinkerton	0	c Castle, b W. F. Forsyth	1
K. B. Alexander, c Wrench, b Baily	12	b Beavan	21
A. E. Clarke, c Castle, b Pinkerton	3	c Baily, b Worsley	12
L. A. Humphrey, c Fielding, b Pinkerton	1	c Forsyth, b Castle	23
N. W. Lavers, run out	0	st Fielding, b Pinkerton	1
P. D. Hunter, lbw, b Baily	0	not out	35
E. G. Goddard, not out	1	b P. Castle	1
H. Barrow, c Worsley, b Pinkerton	0		
Extras	2	Extras	8
Total	43	Total (8 wkts)	143

SURBITON.

F. Fielding, c Fitz-Hugh, b Hunter	3
J. F. Newton, b Goddard	16
W. F. Forsyth, c Perk, b Clarke	18
P. Castle, b Lavers	32
Rev. C. R. Baily, c sub, b Clarke	3
H. A. Forsyth, b Clarke	26
Rev. A. E. Beavan, not out	11
T. Pinkerton, b Clarke	0
V. Howell, c sub, b Perks	0
C. Wrench, c sub, b Clarke	0
Extras	10
Total	119

GUY'S 1ST XI. v. CRYSTAL PALACE.

Played at the Crystal Palace on Saturday, the 18th, resulting in a win for Guy's by 48 runs. We won the toss, and went in. On a slow wicket we began well, Clarke and Perks not being parted till the former was well caught by Wells at point. Alexander had hard luck in being bowled off his pads, when he seemed well set, and directly after Fitz-Hugh came in Perks hit at a loose one, and was caught at short slip. Fitz-Hugh now seemed unable to find anyone to stay with him, and for a time things looked very black: but Goddard, the eleventh man, hit freely and the last wicket put on some 80 runs, bringing our total to 148. Fitz-Hugh and Clarke both played excellent cricket, and Goddard's 23 was got just at the right time. Everybody seemed agreed that the Guy's total was far too small to allow of any chance against such a team as the homeside were: but matters turned out otherwise, and by good bowling and really excellent fielding, we managed to get them out for exactly 100. Goddard kept an excellent length the whole time, and the fielding was so keen that the Palace never took any liberties in the way of running. FitzHugh in particular caught three difficult catches, one of which dismissed Fox, who had made 204, not out, against St. Thomas's the Saturday before. Captain Fleming, the only man who was missed, was the only one to make any score, hitting hard for 39. Scores:—

GUY'S.

A. Perks, c Baker, b Lulham	18
A. E. Clarke, c Wells, b Lulham	47
K. B. Alexander, b Lulham	9
R. T. Fitz-Hugh, not out	30
F. C. Wetherell, lbw b Lulham	0
P. D. Hunter, run out	3
L. A. Humphrey, c Todd, b Fleming	5
N. W. Lavers, b Fleming	1
E. J. Crew, b Fleming	6
A. C. Lansford, b Fleming	0
E. G. Goddard, b Lulham	23
Extras	6
Total	148

CRYSTAL PALACE.

Dr. W. F. Umney, b Goddard	2
C. D. Baker, b Goddard	22
Captain Fleming, b Wetherell	39
J. H. Todd, b Goddard	0
C. J. M. Fox, c Fitz-Hugh, b Wetherell	18
C. Mitchell, b Goddard	2
L. S. Wells, b Wetherell	1
J. C. Umney, c Fitz-Hugh, b Goddard	7
J. F. Dunlop, c Fitz-Hugh, b Wetherell	2
E. H. Lulham, not out	0
P. Aste, b Goddard	0
Extras	6
Total	100

Guy's 2nd XI. have not begun the season very grandly, but we will hope for better things later on.

GUY'S 2ND v. GRANVILLE 2ND.

Played at Lee, on May 4th. Teams—

GUY'S 2ND.

P. D. Hunter, b Helder	1
F. Featherstone, b Davis	7
N. Lavers, b Davis	4
T. Morgan, b Davis	6
C. T. Anderson, c and b Davis	7
H. Durbridge, b Passmore	0
H. Barrow, b Passmore	7
L. Humphry, b Passmore	0
G. K. Levick, not out	9
G. Shorland, b Swann	0
N. Williams, c Helder, b Passmore	2
Extras	2
Total	45

GRANVILLE 2ND.

Wilson, b Hunter	37
Swann, b Hunter	0
Lauder, c Featherstone, b Hunter	27
Taylor, b Humphry	4
Passmore, b Hunter	0
J. Moore, b Lavers	8
Gordon, c Lavers, b Morgan	72
Davis, b Morgan	23
Furze, run out	19
Johnston, not out	23
Helder, b Morgan	5
Extras	23
Total	241

GUY'S 2ND v. CROYDON 2ND.

Played at Honor Oak, May 11th. Teams—

GUY'S 2ND.

F. C. Wetherell, b Neach	35
C. H. Fagge, run out	17
E. D. Hancock, b Paget	18
G. K. Levick, b Paget	2
T. Morgan, b Paget	0
H. Durbridge, b Paget	6
E. I. Spriggs, b Paget	9
C. T. Anderson, run out	31
T. M. Walker, b Paget	0
H. Bignold, b Balch	0
P. H. Ward, not out	0
Extras	29
Total	147

CROYDON 2ND.

G. F. Long, c Bignold, b Wetherell	63
A. P. Patey, b Wetherell	3
C. G. Paget, b Spriggs	0
R. Archer, b Spriggs	3
J. Harris, b Hancock	32
J. W. Clark, b Hancock	2
E. H. Balch, b Wetherall	1
J. C. Neach, not out	16
H. W. Ward, not out	21
C. P. Wick, did not bat	
A. E. Drage, did not bat	
Extras	13
Total (for 7 wickets)	154

GUY'S 2ND v. J. MOORE'S XI.

Played at Honor Oak Park, on May 18th. Teams—

MOORE'S XI.

R. B. Stamford, b Shorland	18
E. S. Tuck, c Durbridge, b Shorland	13
B. Yorath, c Anderson, b Featherstone	59
J. Fry, b Shorland	1
J. Hollingworth, l b w Shorland	3
E. J. Budge, c Barrow, b Spriggs	9
H. Hewitson, b Shorland	0
H. Gill, b Anderson	14
H. J. Spon, c Bignold, b Featherstone	3
J. Moore, b Featherstone	9
A. J. Wernet, not out	3
Extras	9
Total	141

GUY'S 2ND.

E. T. Shorland, c Spon, b Moore	0
E. I. Spriggs, c Tuck, b Yorath	4
F. Featherstone, b Yorath	3
C. T. Anderson, b Moore	13
H. Durbridge, c Tuck, b Yorath	2
A. E. Cawston, b Moore	3
W. M. Thorne, st. Budge, b Moore	2
H. Barrow, b Moore	7
J. T. De Coteau, c Hewitson, b Tuck	20
N. Barron, b Moore	0
H. Bignold, not out	0
Extras	5
Total	59

Guy's Hospital Athletic Club.

THE Annual Sports have been arranged for Thursday, June 6th, starting at 2.30 p.m., and will be held, as usual, at the London Athletic Club Grounds, Stamford Bridge.

The events are the same as last year, and include a half-mile invitation race and a three miles bicycle race in addition to the ordinary events. The sports are unavoidably early this year on account of the date fixed for the Inter-Hospital Sports, June 19th, and this is necessary because the United Hospitals run Cambridge on June 23rd, and the team for this match is picked from the performances at the Inter-Hospital Sports.

It is necessary that the men should go into strict training at once, as the time is short now; we must have the Shield back this year, and this can only be accomplished by training. It is to be hoped that the entries, which close on the 28th, will go up with a rush, as at present they are not coming in as plentifully as could be wished; more especially should we be glad to hear of some running "freshers," as we are distinctly in want of new talent. The races are, as usual, all handicaps, and the team to represent Guy's in the Inter-Hospital contest is picked on the forms shown by the competitors in the various events.

There is every facility for training at Honor Oak Park, where a 100 yards straight and a quarter mile are marked out, as well as high jump, long jump, hurdles, and hammer.

Guy's Hospital Bicycle Club.

FIXTURES FOR ENSUING FORTNIGHT.

May 25.—Meet at Hyde Park Corner at 3.30 p.m. Destination—Bagshot.

" 29.—Meet at Dulwich Village Green at 6 p.m. Destination—Hayes.

June 1.—Meet at Tiger, Lee Green, at 3.30 p.m. Destination—South Darenth.

" 5.—Meet at Streatham Church at 6 p.m. Destination—Warlingham.

" 8 to 10.—Meet at Marble Arch at 3.30 p.m., for Oxford. Full details will be published later.

United Hospitals Boxing Club.

THE Annual Boxing Competition will take place at Store Street Hall, Tottenham Court Road, on the 31st inst. Tickets may be obtained of G. E. Duncan, Secretary of the Guy's Hospital Boxing Club.

Guy's Hospital Swimming Club.

THIS Club bids fair to be a great success this year. An arrangement has been made at the baths, so that members on producing their membership ticket are admitted for fourpence. Tuesday afternoon has been fixed as the club day, and we have first call on the baths on that day for swimming, polo, etc. A strong list of matches has been arranged; amongst others, meeting Old Askeans, University Hospital, and Artists. The team appears to be very strong this year, its only weak point being the absence of a good goal-keeper. If this deficiency is supplied, we should show up well in the Hospital Cup Ties.

At a meeting of the Club, Mr. Fripp was re-elected President; Mr. Fawcett, Vice-President, in the place of Mr. Tubby; and Mr. V. E. Collins, Captain.

Tickets can be obtained from the Committee, Messrs. Styers, Paign, Simpson, Parry, or from the Secretary,

HALLAM HARDY, Hon. Sec.

Guy's Hospital Rifle Association.

THE first match of the present season was shot on Thursday, the 16th instant, at the Ilford range. The match was originally arranged to take place between Guy's and St. Mary's, but at a later date was converted into a triangular Inter-Hospital match, the third hospital being our old opponent, Charing Cross.

We journeyed down to Ilford amid many gloomy forebodings as to the weather, but thanks to the untiring efforts of the inimitable Campbell Jenkins, our spirits never fell very low; indeed the two reassuring elements under the very trying circumstances, mainly of meteorological origin, were the exhortations of Campbell Jenkins and the familiar sight of the genial Charing Cross Secretary, A. E. Street, and his "Box."

The old members of the team, at least, would never entirely lose heart so long as the well-known Box was in their midst; it would be well nigh impossible for a member of the old rifle teams to imagine a match against Charing Cross without the presence of that.

The weather was most unfavourable; the cold, gusty wind caused much involuntary weeping and gnashing of teeth, and the sight of eighteen shivering mortals, each in turn trying to keep the muzzle of his rifle opposite the target was truly touching. In the intervals between the ranges some of the team took refuge in a hut, and tried to keep warm by huddling under some spare mats.

Shooting commenced at 200 yards, but the strong gusty wind made nearly everyone "wobble," and the scores were, on the whole, low. At this range Charing Cross led Guy's by 6 points, but St. Mary's score could not be totalled until the end of the afternoon, Wall arriving too late to shoot at 200 yards until the completion of shooting at 500 and 600 yards. Eventually we tied with St. Mary's at this range.

At 500 yards the tricky wind caused more falling off in the scores of both our opponents than in our own, and at this range we made 111 points as compared with 91 for St. Mary's, and 87 for Charing Cross. On the total of the two ranges we now led Charing Cross by 18 points and St. Mary's (who had another score to make at 200 yards) by 49.

On going back to 600 yards, the shooting of our men showed a slight improvement on that at 500 yards, while the scores of both our opponents showed a marked falling off. Of individual scores at this range, that of Wall, of St. Mary's, stands first, his 28 being highly creditable under existing circumstances. Fulham-Turner, as is his wont, shone most brightly at the long range, and put together 26 for Guy's. Staten, of Charing Cross, stood out conspicuously for his hospital with 23.

Wall now fired at 200 yards, making the top score of the day at that range—namely, 29. The aggregate of the three ranges showed a victory for Guy's by 63 points over St. Mary's, and 84 points over Charing Cross. The scores were as follows:—

GUY'S.

	200	500	600	Agg'te.
C. C. Jenkins ...	23	19	19	61
H. Fulham-Turner ...	20	19	26	65
G. G. Ellis	22	15	20	57
A. Pearson	26	18	17	61
W. B. Secretan ...	19	21	19	59
W. H. Telling ...	18	19	11	48
Totals	128	111	112	351

ST. MARY'S.

	200	500	600	Agg'te.
L. Wells	19	16	15	50
J. Wells	22	20	12	54
J. Pooley	24	20	12	56
Hammond	26	9	2	37
Wall	29	26	28	83
Lightfoot	8	0	absent	8
Totals	128	91	69	288

CHARING CROSS.

	200	500	600	Agg'te.
G. R. Spencer ...	24	9	2	35
A. E. Street	20	13	2	35
H. H. Staten ...	28	23	23	74
G. F. Jennings ...	13	3	0	16
L. N. Lloyd	25	22	16	63
A. E. Walker ...	24	17	3	44
Totals	134	87	46	267

Marriage.

SUTTON—WOLFE.—On April 30th, at Christ Church, Woburn Square, by the Rev. Henry Carter, M.A., of Forty Hill, Enfield, assisted by the Rev. Glendinning Nash, M.A., Incumbent, Charles Robert Arnold Sutton, M.A., M.D. Cantab., of Sidcup, younger son of R. C. Sutton, of Carisbrook House, Forest Grove, Nottingham, to Charlotte Amelia, eldest daughter of James W. Wolfe, of 20, Russell Square, W.C., and Oakfield, Hitchin.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

JUNE 8, 1895.

Leucocythæmia.

CLINICAL LECTURE BY DR. SHAW.

THERE are at present two cases in Clinical ward, of which one is a straightforward case of splenic leucocythæmia in an adult male; the other is a very doubtful case in an infant aged 16 months. I will consider the ordinary course of the disease and some of the difficulties that may arise in its diagnosis, as illustrated by these cases.

But those of you who know the course of this disease may ask, Why spend time in considering the diagnosis of a disease the end of which is perfectly certain, and which we can in no way alter? The apology I would make for doing so is, that though at present we are unable to cure the disease, we may, by following up our research, get a better conception of the disease, and eventually find a remedy. We should be encouraged by the history of myxœdema, the symptoms and pathology of which were long known before anything was effected in the way of cure; now there is no disease in which you can more confidently promise a decided measure of relief to your patient.

The chief symptoms of leucocythæmia are very easily recognised. These are:—

1. Enlargement of spleen.
2. Altered condition of blood.

There are also less constant symptoms, some of which may be caused by these, and others have an independent origin.

(1) *Enlargement of Spleen.*

The first question arising is whether the tumour felt is an enlarged spleen at all. I will not enter into the differential diagnosis of a splenic tumour from all other tumours for which it may be mistaken, but give the chief points that indicate such a tumour.

The enlargement of the spleen in leucocythæmia is generally very marked, the tumour sometimes occupying almost the whole of the abdominal cavity, and, generally speaking, it may be said the larger the tumour the more easily is it recognised as of splenic origin. The position of a splenic tumour is in the left hypochondrium, extending upwards under the ribs, so that its dulness in the abdomen is continuous with the splenic dulness in the thorax. The tumour is also very superficial, so that nothing is felt between hand and tumour. In accordance with this observation made by percussion, it is impossible by palpation to define the upper edge of the tumour which lies in contact with the diaphragm.

In the case of the infant it is easy to get your hand above the tumour and feel its upper edge, and the question has arisen whether this excludes a splenic tumour. I think not. I remember to have seen two cases in the wards in which a similar observation was made.

For this to be possible, it is evident that the spleen must be displaced from its normal position.

In one of these two cases, a man, there was definite history of an injury, and in the other, a woman, there had been tight-lacing, which had considerably altered the shape of her liver, and it was thought probable that this had also caused the spleen to fall from its shelf, lower down in the abdominal cavity.

Apart from this question of displacement, the tumours that most commonly give rise to difficulty in diagnosis, are cancerous masses in the

stomach, in the splenic flexure of colon, or in the peritoneum itself.

Lastly, a tumour that may be mistaken for a splenic tumour is an enlarged kidney. From this, however, it should be generally easily distinguished by the relation of the colon.

In the majority of cases the recognition of the characteristic notches along the internal border of the spleen affords most conclusive evidence of the nature of the tumour.

The second symptom was long ago recognised, and was called "suppuration of the blood." This is due to the enormous increase in the proportion of white corpuscles in the blood, and the condition is now termed "leucocytosis."

The proportion of white to red corpuscles in healthy blood varies from 1 : 250 to 1 : 350.

In the man in whose blood the corpuscles have often been counted, the proportion has been occasionally 1 : 3, and proportions of 1 : 5 and 1 : 6 have been repeatedly observed. The proportion in recorded cases is commonly observed to be from 1 : 2 to 1 : 10. When there is this large proportion of white corpuscles, there is no hesitation in coming at once to the conclusion that the case is one of splenic leucocythæmia.

But it is when the proportion is much less marked than this that difficulties arise; for example, in the child's case the proportion is 1 : 100, which is a decided variation from the normal, but still a small proportion compared with the above. It would simplify matters if one could say that if the proportion is 1 : 40 or more, it is a case of leucocythæmia, and if proportion is less than this, that it is not.

But no such statement can be made. The cases cannot develope all at once. There must be intermediate stages between the normal spleen and the enormous spleen by which we are in the habit of recognising leucocythæmia, and the same must hold good with regard to the leucocytosis.

In addition to this change in the proportion of white to red corpuscles, there are changes in the white corpuscles themselves. If you examine them on a warm stage you will find that they are more inactive, *i.e.*, more sluggish in their movements. If you stain them with eosin you will find that they stain more easily than they do in health, and if you examine them carefully you will find that they are more granular.

Again, there is not only an increase in the proportion of white corpuscles to the red, but there is an actual diminution in the number of red corpuscles, giving the patient a more or less definite anæmic appearance.

This disease, in fact, used to be called "splenic anæmia," but Dr. Wilks long ago pointed out that this was not a very appropriate name, as many advanced cases had no marked pallor. Some, indeed, would trace all the other symptoms that I have yet to narrate as being caused by this anæmia, and it is true that the majority of them are common to this disease and pernicious anæmia.

For example, there is often a marked tendency to hæmorrhage. These hæmorrhages occur spontaneously, without any apparent cause. Some of you may remember the case of a man who lately died in one of our wards from such a hæmorrhage. A large fluctuating swelling suddenly developed on the side of the chest, and this was found to be an enormous hæmorrhage into the muscles of the thorax.

Hæmorrhage often occurs also in the retinæ, and is not uncommonly associated with a very definite optic neuritis and with regenerative changes in the retinæ, producing white lines along the course of the vessels. In our case the backs of the eyes are perfectly normal, and the only tendency to bleeding the patient has shown was when a tooth was drawn, which continued to bleed, despite all treatment, for 48 hours.

There may be also purpuric spots on the legs, or a patient may die with symptoms of cerebral hæmorrhage, a spontaneous hæmorrhage having taken place in his brain.

The way that the hæmorrhage takes place is not exactly known. It is possible that the white corpuscles, by adhering to the sides of the vessel, cause plugging of small arteries and so lead to hæmorrhage; in support of this view may be mentioned the infarction of the spleen often found after death. Two other symptoms common to this disease and profound anæmias are pyrexia and anasarca. The pyrexia may be very marked and is generally variable, periods of normal temperature alternating with the feverish state. Our patient observes that his feelings of discomfort and weakness are almost confined to his periods of feverishness. Often when his temperature is raised he has noticed that his spleen becomes more tender and more prominent, the last-named observation being fully confirmed by the clinical assistant.

The anasarca is probably due to the watery state of the blood allowing it to transude more easily through the vessels. In some cases there is ascites, and this is undoubtedly present in our patient. Again, there may be an effusion

into the pleural cavities. It is doubtful whether there is a slight pleuritic effusion in this case or whether the physical signs are caused by the compression of the bases of the lungs by the abdominal distension.

In some cases there is an effusion into the pericardium, which may be more or less sudden. I remember a case in Mary ward which was thought to be progressing favourably, but one night she suddenly died. I had examined her the previous morning, and felt confident that there was no effusion into the pericardium. But on making a post-mortem examination, a large quantity of fluid was found in the pericardial sac.

In common with many other cases, our patient presents marked tenderness on pressure on the sternum. Tenderness may be noticed in other bones and is generally believed to indicate changes in the marrow, which have often been demonstrated after death.

I have reserved to the end the symptom that I consider of least importance, viz., the enlargement of the lymphatic glands. This I have done because it is by no means a constant symptom, and because the prominence given to it has led to an unnecessary confusion with a very different disease named after Dr. Hodgkin. There is never any marked enlargement such as would draw the patient's attention to it, but rather such enlargement as can be made out only on careful palpation.

In this respect it differs markedly from Hodgkin's disease, in which there is a large tumour in neck or axilla, and the patients come up in order to get relief from the tumour itself.

Post-mortem Conditions. — The enormous spleen above described on section does not differ much from ordinary spleen except in size. There is, however, some evidence of capsulitis. This inflammation of the capsule often leads to the tumour becoming adherent, which, taken in conjunction with the uniform tendency to hæmorrhage which cannot be controlled, is sufficient reason why removal of spleen should never again be attempted as treatment. The spleen often also presents the hæmorrhagic infarcts before referred to.

The Blood is much more watery than normal, and has a lakey or crushed-strawberry colour, often distinctive enough to enable the experienced to recognise the disease from its appearance alone.

It is not known whether this condition of the spleen is the cause of the alteration in the blood, or whether it is secondary to this change in the blood. However this may be, it is pretty certain that the two conditions go very well together, the one progressing proportionately with the other.

The Treatment of the disease is not at all satisfactory. Though we cannot cure the disease, considerable improvement may take place, as shown by the diminution in the number of corpuscles.

There is one drug which is said to have good effect, and that is arsenic. Arsenic indeed has the unenviable reputation of possibly doing some good in cases which are practically incurable, such as Hodgkin's disease and pernicious anæmia.

The man had been in other hospitals before admission, where he had been treated with full doses of arsenic, and his experience was that he felt worse after it. We tried it, but the patient had the firm impression that he was worse after it, and when it produced marked depression we discontinued it. Thus, getting no improvement, it was decided to try phosphorus, which at one time had the reputation that arsenic has now. We gave it in the form of the Syrupus Trium Phosphatum of the Guy's Pharmacopœia, and there is certainly improvement both in the proportion of his corpuscles and in his general condition. In addition to these two drugs, inhalations of oxygen have been employed at intervals during his stay in the Hospital.

Some say that there are no difficulties in diagnosis of this disease, and in order to test this statement I decided to look through the Medical Registrar's index for the last six years, and I found that eight out of the twenty cases indexed as leucocythæmia were marked with a query, the diagnosis being doubtful.

One half of these eight cases must really be excluded, because the uncertainty arose by reason of there being no record of the condition of the blood, without which the diagnosis of leucocythæmia cannot be attempted. In one case it is stated that the patient refused to be "operated" upon; in the others the clerk does not mention upon whom the responsibility for the omission rests. As to the others one was a case of undoubted Hodgkin's disease, with such a moderate leucocytosis as is not uncommon in that condition. The others were cases of enlarged spleen, without blood changes, any other explanation of the enlargement being thought to be inconclusive. Two were, however, probably cases of cirrhosis of the liver, and the

third a case of gastric ulcer with thrombosis of the splenic vessels.

I came across no case in which marked leucocytosis was present without enlargement of the spleen, such as have been described under the title of myelogenous leucocythæmia. Such cases are very rare, and the absence of one from our records during so short a period would not be surprising even if the blood were as systematically examined as the urine. What struck me most was the absence of any case in which doubt existed, on account of the slightness of the enlargement of the spleen, and the unpronounced condition of the leucocytosis. If I have ever seen such a case it has made no impression on my memory. The indefiniteness of this disease in its earlier stages, and the comparative absence of any symptoms likely to attract the patient's attention, are sufficient reasons to explain our failure to make an early diagnosis, while, on the other hand, the much greater chance of our being able to influence the disease by drugs before it has become confirmed should encourage a much more frequent examination of the blood than is at present usual.

A Case of Strangulated Hernia.

A CASE of strangulated hernia, in which a part of the abdominal viscera was protruded into the left cavity of the chest.

The following account of this case, which was only discovered "in a subject brought for dissection to the Anatomical Theatre of St. Thomas's Hospital" by Sir (then Mr.) Astley Cooper, who was lecturer on anatomy, is abstracted from a volume of "Medical Records and Researches selected from the Papers of a Private Medical Association" and published so long ago as 1798. The case is a remarkable one, not only from the rarity of the condition, but also from its long history.

"Sarah Sloman, æt. 28, had from her childhood been afflicted with oppression in breathing. As she advanced in years, the least hurry in exercise, or exertion or strength produced pain in her left side, a frequent cough and very laborious respiration." The account goes on to say that the patient was thought to be "indolent," and she was accordingly "forced to undertake employments of the most laborious kind."

This treatment failed to cure the woman of her apparent indolence, and from time to time, after "any great exertion, she was frequently attacked with pain in the upper part of the abdomen, with vomiting, and a sensation, as she expressed it 'of dragging to the right side,' which sensation she always referred to the region of the stomach. The cessation of these symptoms used to be as sudden as their accession"; apparently, then, the patient was suffering from an occasional subacute gastric disturbance. The attacks were more frequent as she advanced in life, and were of longer duration. The account proceeds: "Some days previous to her death she was seized with the usual symptoms of strangulated hernia, viz., *frequent vomitings*, *costiveness*, and *pain*, the pain confined to the upper part of the abdomen, which was tense and sore when pressed." Mr. Cooper could find no local swelling which indicated the existence of hernia, and it was accordingly supposed that the symptoms had been produced "by an inflammation of the intestines"; but much obscurity was occasioned with respect "to the true nature of the complaint," and as "she was unable to lie on her right side, had a constant pain in the left, a cough, and difficulty in breathing," there was indication of disease in the thorax. The patient died on the fourth day from the commencement of the symptoms which remained in the thorax as violent as at first.

At the dissection of the body made by Mr. Cooper "there appeared a very unusual disposition of the viscera." The stomach and liver were pushed over towards the right side, and the small intestines were found to retain their usual situation, but "lines of inflammation extended along such of their surfaces as laid in contact." When the large intestines were examined it was found that "the great arch of the colon," transverse colon, had "been pushed into the left cavity of the chest, through an aperture in the diaphragm." A considerable portion of the omentum was "protruded into the chest through the same opening. . . . . The protruded omentum and colon were found between the lung and the diaphragm, floating in a pint of blood-coloured serum . . . . . not contained in a sac, as in cases of common hernia." The opening in the diaphragm was in its muscular part, circular, and two inches in diameter, its edge, at which the peritoneum terminated abruptly, smooth, but thickened. The left lung was compressed to about one-third of its natural size, and placed at the upper part of the left chest, and adherent to the costal pleura. The right lung and heart were in a sound state.

Mr. Astley Cooper's remarks on the case are so full of interest, and present such a clear clinical picture, that there can be no hesitation in reproducing them in full. He considered it singular from the size of the opening and the importance of the diaphragm as an agent in respiration, that the disease had not proved fatal at an earlier age; "but it is probable that the aperture had been originally small and had been gradually enlarged by the protrusion of the abdominal viscera.

"Before it became thus dilated, it was probably closed in common inspiration by pressure from some abdominal viscus, most probably by the omentum, as this adhered firmly to its edge. But under the deeper inspirations consequent upon extraordinary exertions, the abdominal viscera, instead of simply covering the orifice, were

forced into it, and then becoming compressed by its edge, slight symptoms of strangulation succeeded; hence the sickness, pain, and the dragging sensation of which she so frequently complained. The situation of the aperture however favoured the descent, and consequently the return of the protruded parts into the abdomen; the symptoms therefore, although they so frequently recurred, remained only for a short time and then suddenly disappeared.

"By these frequent protrusions the opening became gradually enlarged, by which she was rendered more liable to subsequent attacks of pain and sickness, because the viscera entered the chest with greater ease, and in larger quantities. At length a large proportion of the omentum and intestines were forced through the opening; their bulk prevented their return, and the pressure of the edge of the opening . . . . not only occasioned inflammation in the protruded intestine, and all the common symptoms of strangulated hernia; but also by pressure on the lung produced oppression in breathing, pain in the left side, and a difficulty in lying on the right.

"This disease may be known in the living subject, by the combination of symptoms of strangulated hernia, with those of an inflammation in the chest, viz., vomiting, costiveness, hiccough, pain and tension of the abdomen, together with cough, oppressed breathing, and an inability to lie on one side, occurring in a person only a few hours before in perfect health."

The surgeon concludes that in any future case of this disease "the erect posture will be found the most favourable to the return of the protruded parts into the cavity of the abdomen, and the warm bath, with the other remedies commonly used, will, of course, be equally proper in this as in other cases of strangulated hernia."

The conclusion of his contribution deals with an inquiry as to how the abnormal aperture in the diaphragm was first produced. Mr. Cooper cites a case of a man who, after an injury, sustained a laceration of his diaphragm, which was the cause of hernia into the left chest. He is of the opinion, however, that in the case of the woman whose case he has described, "there existed an original malconformation of the diaphragm. As proofs of this opinion, we may state the very early age at which the symptoms were first observed; they being evident when she was yet in arms!" There was no history of any violence, and "a lacerated opening is generally irregular; this was smooth and circular! . . . Morgagni relates some instances, from Bartholin and others, of a part of the abdominal viscera being found in the cavity of the chest without any preceding violence; and, farther, that such a defective state of the diaphragm does sometimes occur, is proved by two preparations of infants in the anatomical collection of St. Thomas's Hospital." E.

In the Guy's Museum are five specimens (1085-1089) of Diaphragmatic Hernia, two of which are preparations from fœtuses, showing a congenital deficiency in the left half of the diaphragm.

A Case of acquired Syphilis in a Child aged Six.

A CASE of *acquired* syphilis in a little girl aged 6, under the care of Mr. Brook, who has kindly allowed me to publish it. She was a healthy little girl, admitted for "growth on the tongue."

Family history.—Father and mother alive and well; one brother and one sister alive and well; one died of consumption of bowels. Patient is the eldest child and has never had any illness before.

History of present disease.— Present trouble commenced seven weeks ago. Came as a little pimple on the tongue. Doctor cauterised it. Since then it has grown steadily worse. Not much pain. Lumps under jaw appeared soon afterwards.

Condition on admission.—Well nourished child. Lumps under lower jaw in position of submaxillary glands. Hard, freely movable; painless. A raised patch on middle line of tongue about the size of a shilling; it is about the junction of anterior and middle thirds. It has a raised hard margin; it is painless.

January 17th. A pink papular rash has appeared on front of chest and abdomen.

19th. Rash scaly, darker. White patches on tonsils. Patient put on Hyd. cum Creta. gr. i.

21st. Rash nearly gone.

30th. Rash gone; sore on tongue smaller; base still hard.

February 9th. Sore on tongue much smaller. Patient discharged.

Cases of acquired syphilis at this age are rare. There were no signs of congenital syphilis. Both parents were healthy. Mr. Jonathan Hutchinson kindly examined the patient and confirmed the diagnosis. Histologically a piece of the growth showed granulation tissue and enlarged papulæ—it felt exactly like a Hunterian chancre. There was a history of the child having blown bubbles with a clay pipe, which might account for the infection. S. FLOYD.

A Case of Meningocele.

ON Tuesday, May 13th, a case of loss of anterior occlusion (open bite) presented itself for treatment at the Dental School. The age of the child is 14, and up to the present no attempt had been made to remedy her condition. The want of occlusion is well marked, so much so that the front teeth are separated by an interval of almost an inch when the molars are closed.

The teeth are mostly carious, and require a passing reference, as the cause is evidently due to an arrest of development, as is that of the major defect producing the "open bite." This is plainly marked, the ascending rami of the inferior maxilla, whose angle normally a

this age (14) is almost a right angle, is extremely oblique, participating more of the form of an infant's than of a well-developed jaw, and is also considerably smaller in proportion than the upper jaw. Altogether, then, the signs of arrested development are evident and require mention, on account of their bearing upon the case.

During the examination, it was noticed that when the patient inclined her head to the left, a swelling appeared, about an inch from the extreme angle of the left supra orbital ridge, nearly horizontally backwards; it exhibited no pulsation, and was not painful upon pressure.

The history did not throw much light upon the subject. The swelling seems to have always appeared when the head was depressed, and had never caused any inconvenience; there was no nasal discharge, nor any foul taste in the morning; no tenderness over the antrum of Highmore; no supra-orbital or frontal headache. She had once suffered from slight headache, but this had been confined to the right side. She has had few childish ailments, in fact she was kept in the room with the other children when they were suffering from measles, and did not contract them. She was unable to walk till three years of age, and had attacks of bronchitis as each tooth was erupted. Father and mother have always enjoyed good health, and the patient herself at the present time is well and fairly bright, though dull at school.

The site of the swelling is just above the tip of the greater wing of the sphenoid and the anterior inferior angle of the parietal, where a slight discontinuity may be felt, corresponding evidently to the left lateral fontanelle, normally closed soon after with the pterion ossicle. The swelling, which evidently contains fluid, disappears almost immediately the upright position is regained, the child often accelerating matters with a slap. As before stated, there is no pulsation, nor is there any pain, although a headache supervened upon the examination. These facts, then, the oblique rami due to mal-development, the small jaw, and badly calcified teeth, all tended to point to a non-closure of the suture, and that the fluid was of cerebral origin. However, not liking to risk a wrong diagnosis, the case was taken to Mr. Symonds, who kindly examined it, pronouncing it to be a meningocele, and in a somewhat rare position.

To those interested in the recondite processes of development, this case is peculiarly interesting, for there is here a striking similarity in the condition of the inferior maxilla, the teeth in it, and the non-closure of the lateral fontanelle, all evidently due to an insufficient deposit of lime salts; and it is not altogether surprising when the blood-supply of the parts is considered, upon which consideration John Hilton so often insisted, for would not any cause affecting the internal maxillary artery also affect the inferior dental and the middle meningeal at the same time?

It is certainly not misplaced, then, to describe this case as full of interest.

K. W. GOADBY.

Plaster of Paris Impressions.

THE models used by Dental Surgeons are nearly always made by running plaster of Paris into impressions of the mouth taken in gutta-percha, wax, or modelling compositions, of which the best known are those called "Godiva" and "Stent." The two latter are very much alike and largely consist of Kauri gum and French chalk, and for the construction of artificial dentures either of these compositions will yield a satisfactory model. But there are cases in which great accuracy is required, as, for example, where it is necessary to obtain a model of the soft palate extending backwards to the uvula, giving the exact representation of the soft parts in a condition of rest. I do not know of any material excepting plaster of Paris, introduced in a semi-fluid condition and allowed to harden *in situ*, that will give the perfect mould required, and a few practical hints in the method of taking a plaster impression of a cleft palate may prove useful to Dental students.

In the first place, a special impression tray, extending to the back of the hard palate, should be cast in pewter. I know that a high authority has said of special impression trays that "they are but the leading strings of infants," but I recommend a special tray in every case, because a thin uniform layer of plaster can be used, and there is much less risk of a gush of half-set plaster finding its way into the pharynx. When one is modelling the velum palati it is prudent to recollect the position of the larynx, and no precautions should be disregarded.

Having cast the pewter tray of the length indicated, it should be tried in the mouth in order to see that it does not press upon any part of the palate, and that the soft palate is hanging just free. The tray has now to be extended so as to cover the soft palate without the least pressure. This can be done by adding a sheet of wax or gutta-percha to the back of the tray, or by riveting on a wing of thin metal plate. I have recently found that a piece of very thin pewter can be moulded with the fingers and fixed to the tray by gutta-percha. The extension should not be carried beyond the uvula, the tip of which should be seen hanging free of the plate at its posterior margin. The irritability of the palate can be allayed by a solution of cocaine applied on a pellet of wool, or by means of a spray. Before proceeding to mix the plaster the position of the head should be carefully adjusted, with the chin depressed: this is a point that must not be forgotten. Fresh plaster of Paris should be used, and salt, rouge or alum may be mixed with the water to hasten setting. I prefer a saturated solution of alum, because it is always the same strength, and if one uses good plaster which has been kept in an air-tight tin, a uniformity of result is approximately obtained. The plaster should be mixed in a very small basin, or in a cup, standing in a larger vessel of warm water, for the application of cold plaster to the soft palate is prone to cause muscular contraction that spoils the model. Mix the plaster rather thin, and line the

impression tray with a layer not more than a quarter of an inch in depth. Don't put much plaster near the edges of the tray, especially over the soft palate, for a little is sure to squeeze out. Directly the plaster begins to set, convey the tray into the mouth, and gently press it into position, holding it in place with the left hand. With the other hand spread some waste plaster along the rim of the basin, and watch the progress of setting. As soon as the waste plaster breaks with a clear line of fracture the impression must be removed from the mouth, for the plaster in the mouth sets a little quicker than in the basin owing to the higher temperature of the mouth. To remove the impression, depress the handle of the tray gently and allow the plaster to fracture if necessary. If there be difficulty in removing the tray remember that delay will only increase the difficulty, and remove your tray at once, even if you spoil the impression. Detached portions of the plaster impression should be replaced in the tray and fixed with wax or varnish whilst the mould is filled with plaster. The surface of the impression should be varnished or soaped to facilitate the separation of the model from the impression.

In this way accurate reproductions of almost any oral deformities can be obtained, but I look on plaster impressions as rather unsuitable for the lower jaw, or where there are loose teeth. If there be one or two long teeth standing in the mouth, it is well to protect them with a thin covering of wax or gutta-percha, and if they converge the intervening space may be cored. Another way is to cut a hole through the impression tray, which effectually prevents a tooth from becoming caught in the plaster. Excellent practice in taking plaster impressions can be obtained by any student who makes a special tray, and practises taking the model of his own palate.

F. NEWLAND-PEDLEY.

Examination Papers.

Royal College of Surgeons of England.

DIPLOMA OF FELLOW.

FIRST EXAMINATION.—ANATOMY AND PHYSIOLOGY.

Anatomy.—1. Write an account of that part of the Base of the Skull bounded in front by a line drawn immediately in front of the bases of the Pterygoid processes, and behind by one passing through the apices of the Mastoid processes. 2. Describe the Arches of the Foot, and give an account of the Structures by which they are maintained. Explain how Weight is transmitted through them to the ground. 3. Write an account of the Thyroid body, including its development. 4. State precisely the distribution of the Cutaneous Nerves of the Upper Extremity.

Physiology.—1. What variations in (*a*) pressure and (*b*) velocity does blood undergo in making a complete circuit of the vascular system? Explain how these variations are brought about, citing experimental evidence in support of the statements you make. 2. Describe Gastric Proteolysis, naming the several chemical substances successively produced during the process. State how you would separate each substance and give its characteristic reactions. 3. What is Electrotonus? Explain in detail how it is produced. By what method would you demonstrate the electrotonic variation of the excitability of a nerve? 4. Describe (*a*) the development of the Eyeball, and (*b*) the minute structure of the two outermost layers of the Retina.

Viva-Voce.

CANDIDATE was ushered, with three others, into a large room occupied on one side of a row of pillars by four elderly physiologists, and careworn examiners leaving the room; and on the other by four anatomy examiners. On the scene were divers tables, on which were specimens more or less familiar.

1. Candidate was shown a dried pelvis. Was asked to which sex it belonged, and replied, female.

Was it typical?—No, I should say not.

What are the distinguishing features of the pelvis in the two sexes?—Candidate replied wrongly as to curvature of sacrum; declined to answer as to vertical diameter; answered as to other diameters and infrapubic angle correctly. Pelvis turned out to be male. Difference as to thyroid foramen asked. Candidate affirmed that it was not given in the books he had read.

2. Candidate was shown femur, and asked to map out attachment of muscles to upper half with white chalk. Endeavoured to give an impressionist view of the attachments; but could not satisfy examiner as to precise extent of each muscle; nor as to an area he had left bare below post-intertrochanteric line.

What is the use of the long neck of the femur?—To maintain erect position.

What *else*?—*To give elasticity.*

Why is it so long?—To give wider range of movement.

No. Does the head fit tightly into its socket?—Yes; but the capsule is loose.

What would be the result of the head of the femur being placed directly on the shaft?—No answer was given.

3. Candidate was shown an ordinary specimen of brain dissected so as to show third ventricle from above, with descending horn of lateral ventricle displayed on one side. He was allowed about half a minute for examination of the specimen, while the examiners conversed affably together. Candidate was asked as to the ventricles of the brain, the corpora quadrigemina, medullary velum, hippocampus major and minor, the tænia and pes hippocampi, eminentia collateralis and collateral fissure, choroidal plexus and velum interpositum.

He was further asked as to the relative positions of the caudate and lenticular nuclei.

What separates them?—Oh, a few white fibres.

What fibres are they?—Well, a part of the internal capsule separates them.

What lies outside the lenticular nucleus? — The external capsule.

Are those two neuclei joined together in any part?—No, I don't remember them being united in any of the pictures I have seen.

Oh, but that is quite wrong. You must not learn your anatomy by pictures.

4. Examiner took up a left trapezium bone, and asked its name, side, position, and points by which it was recognised.

5. Candidate was shown a dissection in spirit, displaying the inside of the lower jaw, pterygoid processes and turbinate bones, with the casserian ganglion floating free, fixed only by its roots, of which the inferior maxillary, with all its branches, was clearly dissected out. These, and the branches of the internal maxillary artery, were in turn pointed out for recognition, and only one branch, ascending internally to the auriculo-temporal nerve, was wrongly returned as the deep temporal artery. The branches of the submaxillary ganglion were asked, and questions concerning the site of the submaxillary gland, the arrangement and the nerve-supply of the mylo-hyoid muscle, when at last the bell sounded.

In physiology, candidate made great friends with the examiner, and conversed on sundry topics of interest, physiological and metaphysical, until the marking examiner expressed his opinion that metaphysics was not a part of that examination.

Candidate was shown a bad specimen of mammary gland, and very nearly declared it to be pancreas or epididymis, owing to a peculiarity in the staining; but being permitted to use the high power, and having heard that a previous unfortunate candidate had been shown a section of mammary gland, he at length gave that as his answer. He was asked what black stain might have been used for the purpose, and replied at first wrongly, aniline blue-black, and then corrected himself to osmic acid. The examiner here differed from the candidate in declaring that the osmic acid blackening of fat was insoluble in chloroform and other clearing media, to which, however, for expediency, he gave his assent.

A second section was shown, and was recognised as being that of the cardiac end of the stomach. (Supra-renal body was suggested under low power, but the high power and a full minute's reflection, which was readily granted, prevented this mistake being made).

A cast of the cerebral hemispheres was shown, and their function asked. Candidate replied with an account of Goltz's experiments on dogs, which showed that they were of very little essential value in lower mammals; in men they were said to subserve the functions of automaticity and volition, part being marked out as purely sensory and part as sensori-motor in function. The examiner appeared interested, and a discussion ensued on the question of volition.

Candidate was shown a fœtus and placenta, and was asked the use thereof. Presuming that reference was made to the placenta only, he replied that its function was the renovation of the fœtal blood.

How is this effected?—By a kind of vital osmosis.

This led to a discussion on vitalism, which the candidate continued vigorously, in order to keep his examiner's attention off a piece of bread, marked with sundry colour-tests, that forbode evil. This was successfully avoided. It was asked if the vitalism of the placental cells was of a higher order than that of the cerebral cells, and a negative answer given.

A third section, also of indifferent quality, was shown of the eye at the corneo-sclerotic margin, and after a considerable interval, recognised, although the unstained cornea was at first answered as being a preparation of white fibro-cartilage. The use of the iris was then asked, and the question of spherical aberration discussed somewhat unsatisfactorily.

Finally curves were shown, illustrating respectively the fatigue of muscle and the composition of tetanus, and satisfactory answers given as to the way in which they were obtained.

Candidate, to his considerable astonishment, passed, and wishes here to testify to the uniform courtesy and fairness of the examiners and officials of the College whom he came across, and to the "glorious uncertainty" of the whole system of examination, by which he, without doubt, profited. F.

University of Durham Faculty of Medicine.

Examinations in Medicine and Surgery, College of Medicine, Newcastle-on-Tyne, April, 1895.

Final Examination for the Degree of Bachelor in Medicine.

Paper No. 1.

Principles and Practice of Medicine.—1. Sketch the clinical features, the diagnosis, and the treatment of a case of Acute Biliary Colic. State fully the indications for the subsequent treatment of the chronic biliary affection. Write prescriptions for the acute as well as for the chronic condition. 2. Point out the differences between the early and the late Hæmoptysis of phthisis, with special regard to their mode of production and to their prognosis. State clearly the principles which should guide the general and medicinal treatment of severe hæmorrhage from the lungs, giving the doses of any remedies suggested. 3. Enumerate and briefly describe the various affections of the brain and of its membranes to which syphilis may give rise; and mention, in each case, the prospect of recovery under appropriate treatment. 4. Describe the symptoms of Tubercular Meningitis in children, and give the differential diagnosis of the condition from Enteric Fever. Give the treatment of the condition, medicinal and hygienic. 5. Review the causation of Pyelitis, and give the symptoms, diagnosis,

and treatment of the condition. 6. Give a definition of Lupus. Mention the forms that may occur, and describe their appearances and treatment, local and constitutional.

Paper No. 2.

Principles and Practice of Surgery.—1. Describe a case of acute Osteomyelitis, giving the pathology of the disease, and the treatment you would adopt. 2. Describe the operation of venesection at the bend of the elbow, mentioning the structures which are cut, and the possible accidents which may occur in performing the operation. 3. What circumstances would induce you to express the opinion that a certain ulcer on the tongue was malignant? 4. Give the relations of the trachea. 5. Give the signs of fracture of the neck of the femur. What treatment would you adopt? Mention the complications likely to arise in the course of the case which are sources of danger to life. 6. Enumerate the causes of acute Epididymitis, and give the principles concerned in the treatment of this disease.

Paper No. 3.

Medical Jurisprudence and Public Health.—1. Explain the difference between the terms "common witness" and "skilled witness." 2. How may the validity of a will be affected by the bodily disease of a testator? 3. Describe a fatal case of poisoning by oxalic acid. 4. Describe a typical case of acute Melancholia. 5. Name the signs of wholesomeness and potability of Water. Indicate the ordinary forms of pollution of Water, and the means of detecting them. 6. What diseases are spread through the medium of cow's milk, and by what circumstances should your suspicion as to the probability of such spread be aroused?

Paper No. 4.

Midwifery and Diseases of Women and Children, and Pathology.—1. Describe the ordinary mechanism of delivery in Presentation of the Head in the third position (O.D.P.) What causes may prevent the forward rotation of the occiput during labour? and how would you manage a case thus retarded? 2. What causes may produce rigidity of the Os and Cervix Uteri in the first stage of Labour? What treatment, local and constitutional, would you adopt to overcome this difficulty? 3. What are the symptoms and signs of Accidental Hæmorrhage in the seventh month of Pregnancy? What causes tend to produce it, and how would you treat such a case? 4. Give the symptoms, signs, diagnosis and treatment of retroflexion of the Unimpregnated Uterus. 5. State how you would recognise, in the *post-mortem* room, the pathological conditions:—Leukœmic Kidney, Tubercular Meningitis, Septic Gangrene of the Lung, Syphilitic Cirrhosis of the Liver. 6. Give a brief description of the joints in Arthritis deformans. 7. Compare the blood in the following morbid states:—Anæmia from malignant disease, Pernicious (Addison's) Anæmia, Leukœmia, Chlorosis. 8. Describe the microscopical appearances of a lung in Lobular Pneumonia.

Viva-Voce.

Ten Minutes at each Table.

MIDWIFERY.

Candidate was asked to name Hewitt's, Galabin's, and Hodge's pessaries, and to state when they are used.

Also shown a decapitating hook, and asked to show how he would use it.

In a neglected shoulder presentation would you at once decapitate?

How would you remove head afterwards? Would uterus expel it?

Was shown a Budin, and asked when it was used.

If a child's legs were outside vulva, how would you decide it was a hydro-cephalic child?

What would you do?

Suppose you could not reach head, what would you do?

How would you decide a presentation was a breach?

Show on this model how you would deliver a breach.

Define superfœtation and superfœcundation.

Describe exactly how you would treat a case of retroflexion of the gravid uterus at the third month.

How would you diagnose this condition?

To what symptoms would it give rise?

What is the danger of leaving the uterus retroflexed?

How many cases of midwifery have you attended?

Had you anything unusual?

You mention twins, were they in the same bag of membranes; if so, how were they developed?

What varieties of twin pregnancies are there?

[*Bell.*

MEDICAL JURISPRUDENCE.

Candidate was shown three corked test-tubes containing white poisons and asked to name them.

Give me the symptoms of oxalic acid poisoning.

What are the changes seen at a post-mortem?

How would you treat a case?

Is copper sulphate a poison? In a large or small dose?

What would be your treatment?

A woman possessed of property in her own right marries; supposing she dies during child-birth, and child is got out alive, has the father any right to the property.

Name the substance in this bottle.

What are the symptoms of poisoning by perchloride of mercury?

What would you expect to find post-mortem?

What tests would you apply to this substance?

[*Bell.*

PUBLIC HEALTH.

What impurities do you expect to find in reservoir water?

How would you decide typhoid germs were present in water?

Can any house filter be used to prevent these germs being in the drinking water?

What is hardness in water?

How would you get rid of temporary hardness?

What happens on boiling?

Is there any hardness left?

What amount of permanent hardness do you consider allowable in drinking water?

How would you construct a filter-bed?

Why use big stones and shells?

What amount of fresh air does an adult require an hour?

Supposing he were ill in a small room, how could ventilation be arranged for without draught?

Tell me any diseases spread by the mosquito?

Describe the mode of action of the filaria sanguinis hominis, and its life history.

Tell me some other disease of which the cause is an organism in the blood?

Describe the spirochæte Obermeieri.

At what period of relapsing fever is the organism found in the blood?

How would you proceed to disinfect after relapsing fever?

Is it difficult to kill the organism?

How much sulphur do you consider ought to be burnt?

Describe exactly the reaction which takes place when the sulphur is burnt and the products which are formed. [*Bell.*

MEDICINE.

A young boy is in bed, how would you decide he had typhoid fever?

Describe the tongue. Describe the spots.

On palpating abdomen would you notice anything?

What is the cause of the fulness in that iliac fossa?

A man has right-sided pneumo-thorax; how would you prove it?

What cerebral causes are there for an apoplectic attack?

What would you do if called in to a case?

Suppose you have a patient with paralysis of the limbs, how do you proceed to determine where the lesion is?

Suppose the arms only are affected and there is great wasting, how do you distinguish between a central and a peripheral lesion?

What are the commonest lesions (central and peripheral) affecting the arms?

What are the physical signs of pericarditis with effusion?

Where is the heart's impulse seen?

Is this where the actual apex of the heart is situated?

How do you treat a case of ascites from alcoholic cirrhosis? [*Bell.*

SURGERY.

What varieties of spina bifida are there?

What is the cause?

Don't you think it is the protrusion of the membranes that prevent the junction of the bones?

What other congenital abnormalities may you get with it?

What would you diagnose meningocele from? How?

What causes the pulsation?

What is the normal amount of cerebro-spinal fluid present in brain?

Candidate was shown renal calculi.

In what urines do you get phosphates?

What complications follow on cystitis?

Is surgical kidney the same as acute nephritis?

Mention the common tumours of the breast.

Is scirrhus a malignant tumour?

Does it cause the whole breast to enlarge?

Are the glands affected, and if so, which ones?

Would you place scirrhus under the heading of epithelial or connective tissue tumours?

What is a bunion?

What changes may it undergo or set up in its neighbourhood?

What is a corn?

What is perforating ulcer of the foot often associated with? [*Bell.*

PATHOLOGY.

What does that microscopic specimen show? Bird-nest cells.

Describe a syphilitic liver.

Lobar pneumonia—what is the first change? Describe it.

Describe the other changes in order.

How would you tell lobar from lobular pneumonia under the microscope?

Can you get the heart affected in pneumonia?

Might there be any brain changes?

Describe the changes found in a case of ague.

What would the brain look like?

Look down this microscope. (The candidate being unable to name the specimen, was asked what he saw). Cells and pigments (Melanotic sarcoma).

Name the varieties of sarcoma.

Where are myeloid sarcomas usually found?

Give the various ulcerations which occur in the large intestine.

What is the cause of dysentery?

Describe the structure of a tubercle.

What changes may it undergo?

Describe the changes in the lung in emphysema.

Tell me the effects of aortic regurgitation on the heart?

Candidate was then shown a disseminated growth in the liver. [*Bell.*

Appointments.

Skinner, D. S., M.D. Brux., L.R.C.P. Lond., M.R.C.S. Eng., has been re-appointed Medical Officer of Health to the Willesden District Council.

Symonds, Charters J., M.S. Lond., F.R.C.S. Eng., has been appointed Consulting Surgeon to the London and South-Western Railway Servants' Orphanage, *vice* A. E. Durham, F.R.C.S. Eng., deceased.

Turner, George, M.B. Cantab, D.P.H., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Government of the Cape of Good Hope.

Passim.

WE wish to draw particular attention to the letter which appears in another column, asking for donations to the Arthur Durham memorial. Every old Guy's man will, in the course of a few days, receive a copy of this appeal, and we are sure that it will meet with the hearty support of our readers. An opportunity is thus given, not only to all Guy's men, past and present, but also to the many private friends of the late Mr. Durham, to assist in the endowment in perpetuity of two beds, as the best tribute which can be paid to his memory.

THE Committee of the Student's Club have had under consideration a scheme for placing a suitable memorial to the late Mr. Durham in the Club rooms, but have now thought it advisable to incorporate their proposed fund with the scheme notified above. It is, however, hoped that an arrangement will be made whereby a small sum will be set aside to satisfy the very general desire amongst the members of the Student's Club towards the purchase of a good portrait of their late and much esteemed President.

THE patient who was the first of the cases which formed the subject of Dr. Hale White's Clinical Lecture on "Malignant Disease of the Liver" (published in the GAZETTE of February 9th last), recently died in John ward. A full report of the case, lately under the care of Dr. Perry, appeared in our last issue, with an account of the autopsy. It will be remembered that the lecturer drew particular attention to the obscurity of this case, which has since also occasioned many interesting bedside discussions.

THE Annual Report on the Sanitary Condition of the Parish of St. George-the-Martyr, Southwark, for the year 1895, by Dr. Waldo, Medical Officer of Health, has reached us. The condition of a parish with which Guy's Hospital is so intimately connected is of paramount importance, and one or two points upon which Dr. Waldo, in his admirable report, lays some stress are of considerable interest. The Salvation Army Shelter, situated in Southwark Street, has received searching attention at his hands. He emphasises the need of an extension of the powers of the local authority in dealing with such shelters, by reference to two considerations. In 1893, he informs us — and the announcement will be received with some concern — that 31 cases of smallpox were referred, directly or indirectly, to the Blackfriars Army Shelter, and that the overcrowding is simply disgraceful. It sounds incredible, but such are the facts—that whereas in general hospitals each adult patient is allowed 1200 cubit feet of space, in the army shelter, adults are herded together to such an extent that each is allowed but 90 cubit feet! In spite of the fact that this state of things is continually being pointed out by zealous and capable medical officers there appears to be no legal authority to supervise and regulate the proper control of "these philanthropic and semi-philanthropic shelters," and Dr. Waldo does not too emphatically protest against this ridiculous condition of affairs as "a standing menace to the public safety."

MANY of those who have performed the duties of Extern will remember the "insanitary area" of Falcon Court and neighbourhood. A few of the houses in this neighbourhood have undergone structural alterations but with these exceptions the whole of the buildings remain "in much the same insanitary condition" as they were three or four years ago. Dr. Waldo submitted the excellent idea to the London County Council of demolishing the whole of this area and converting it into a modern recreation ground—"So far nothing has been done by the London County Council." The vestry delegates, including the Medical Officer of Health, have since been received by the Housing Committee of the London County Council, and it now remains to be seen if any definite steps will be taken to rid "not only St. George's but the metropolis as well of this unwholesome area."

IN the note on Disinfection appears a remark to the effect that the Sanitary Authority is still in want of a properly constructed incinerator, and it is a matter for gratification to know that this important work is now undertaken by the authorities of Guy's Hospital, an account of which beneficial arrangement appeared in the Annual Report of Guy's Hospital, published in the GAZETTE last year.

THE delay that some members have experienced in obtaining a lawn tennis court at Honor Oak Park will, it is hoped, be obviated

now that courts are being marked out on the outskirts of the cricket ground. The freshly-levelled area just inside the entrance gate would have been available before now but for the prolonged drought. The ill-luck of our ground in the matter of weather still continues—whenever it wants rain none comes—and vice versâ. And so it has been ever since the turning of the first sod in the levelling operations, the result of which is so good that most of us have forgotten what a long and anxious job it was.

THE Annual Athletic Sports were held on Thursday last in brilliant weather, at Stamford Bridge, and before a numerous company. The entries were not large but there were some capital performances in the various events set for decision, although the high wind was not conducive to fast times. A full report of the meeting will be inserted in our next issue.

MR. C. J. FRANCIS, a cricketer of whom Guy's may justly be proud, appeared for Gloucestershire on the occasion of their brilliant defeat of Kent a fortnight ago. We congratulate "the little man" on this distinction, and hope his may soon become a permanent position in the Champion's County eleven.

OUR congratulations are also due to Mr. W. J. Scott, who played a faultless innings of 109 on Thursday last for M.C.C. and Ground, in the match with Warwickshire at Lord's Cricket Ground.

THE second session of the International Congress of Gynecology and Obstetrics will take place at Geneva in September, 1896, and not during the present year, as has been wrongly announced in some journals.

Guy's Hospital Debating Society.

THE "Ladies Night," held on the 25th ult., proved a great success. The audience quite filled the Smoking Room, and at the outset the fair sex were certainly in a majority. Among the number present were Dr. Pavy, President, in the chair, Dr. and Mrs. Shaw, Mr. Lane, Mr. Dunn, Mr. and Mrs. Targett, Mr. Hopkins, Mr. and Mrs. Wade, Miss McLeod, Sisters Clinical, Job, Lydia, Naaman, Mary, Philip, Bright, Accident and Out-patients, Miss Newton, and a strong contingent from the London School of Medicine for Women and others.

Mr. L. A. PARRY, in moving, "That this House emphatically upholds the advantages of a scientific over a classical education," remarked that the ornamental had always taken precedence of the useful. The resolution sought to establish only the relative value of the systems of education referred to. Life was short, and it was of the greatest importance we should learn that which was the most useful. Some of the main advantages of a scientific over a classical training were that it gave us an insight into the laws which regulate man's health; that it was of the greater value in earning a livelihood, and, on the authority of Herbert Spencer, it fitted man to become a good citizen. Historical knowledge was an insufficient guide, and even art and pleasure were dependent on the help which only science could afford. Within the limits he proposed, Mr. Parry's speech was cogent enough to give his side a capital send off.

Mr. HAMBLIN SMITH, in a lighter but attractive vein, opposed the motion. He was glad Mr. Parry had not limited classics to Latin and Greek. As to his contention that the school-boy took more readily to science, he believed this to be much overdrawn. The ordinary school-boy did not much care what he learnt, but possibly might have a partiality for science as taught, because of the accompaniment of odorous and explosive demonstrations. Again, the future profession of a boy could be no guide to the exact form his education should take, because few boys had anything but absurd notions regarding their future occupations. The term "exact science" he described as a sounding phrase. All knowledge was based upon training in method, and his contention was that no better training in method could be given than was now in vogue at the public schools, and he would remind them that every scientific man had had that training. The great objection to science as a training was that it required such a blind acceptance of dogma. It had been said by a great authority that a good physician must be also a poet, the meaning being that whatever a man's training might have been, he would be a failure if he knew all things except the human heart.

Mr. A. P. ALLAN, in expressing his hearty support of the motion bemoaned the terrible spectacle of the son of an eminent mathematician turning against his father. Science controlled our vanity. Scientific men were the most modest on earth, and the Bishops were examples and warnings of the deplorable effects of the best classical education.

Mr. E. COLEMAN opposed the motion in a speech of distinct quality. He maintained that the opener had taken too utilitarian a view of life. The real object of life was the solution of what existence itself meant. Scientific men were trying to get at the source of life, and were no nearer to that now than they were a thousand years ago; but from the sages of the past we might learn how to rightly appreciate life and its actions.

Mr. E. IVENS SPRIGGS contended that nothing could be better for training the reason and will than a scientific

education. Classics were purely decorative, and as few could unite the two sides, he chose the essential.

Miss AMOS, whose beautiful elocution and close reasoning against the motion completely held her audience, followed. It had been said by the previous speaker that the following of science best trained the will, but she claimed this for the classics. It was no easy matter to acquire a scholarly knowledge of a language such as would enable one to reproduce the classics oneself, and the same held good with the reason. Anyone who had studied a language seriously would understand that grammar was not merely a question of learning names, but was a matter into which a great deal of reasoning had to come, and following that line of thought we might include logic and other things which train the reason. From the monetary point of view, it is much less a paying thing to be a scientific than a first-class classical man. That might be because the body of scientific knowledge was still small and the learner found his feet at once, while classical men could not do original work until after long training. Another question arose: For what purpose were we educated? Surely in order to become the best citizens of the world. A first-class scientist was necessarily a specialist; the man of the world was a man who must be interested in everything. He must have his various senses developed, especially the historical sense. The history of science was so very short that she did not think the historical sense was sufficiently developed by its study. The study of classics involved a knowledge of men's manners, of ways of thought during thousands of years. She, therefore, believed that in order to become a citizen in the best sense we must study the classics, or as they were called in the old time, the Humanities.

Miss HOWARD said that one great advantage of the classics was that in them we studied other people's ideas besides our own, which in these days was very necessary. Where, she asked, would science get such grand terms as *hippocampus major* from, if it were not for the classics? Judging from the tone of those who had spoken in support of the motion, the tendency of a scientific education was to produce narrowmindedness.

The debate was continued with spirit by Messrs. Rice, Pendred, Nourse, Ham, Anderson, and Reaside, and the openers having replied, the House divided, with the following result:—

The Society voted—			
Ayes	...	...	21
Noes	...	...	19
Majority for the ayes		...	2
The whole House voted:—			
Ayes	...	...	51
Noes	...	...	46
Majority for the ayes		...	5

A vote of thanks to the Chairman having been passed with acclamation, and suitably acknowledged by Dr. Pavy, the House adjourned.

From the Gazette's Special Pathologist.

ALL specimens — particularly those of solid tissues— should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

F. R. P. B., TUNBRIDGE WELLS.—Sections of this tumour prove it to be a spheroidal cell carcinoma, with patches of colloid degeneration.

W. E. T., NOTTINGHAM.—The sections from this specimen prove the existence of a large-celled carcinoma of the uterus. The epithelial cells are arranged in irregular "convoluted" masses suggesting the original "adenoid" character of the growth.

D., KINGSTON-ON-THAMES.—A blood serum tube was inoculated from the speck on blotting paper, and, after 24 hours' incubation, resulted in a sparse growth, which microscopically proved to be entirely composed of staphylococci. No diphtheria bacilli present.

PATHOLOGIST.

Guy's Hospital Dental Department.

PRACTICE DURING MAY, 1895.

Gold Fillings		567
Amalgam ,, ...		663
Osteo ,, ...		
Perm. G.P.,, ...		
Regulations		6
Artificial Crowns		57
Dentures		37
Dead Teeth		205
Scalings		73
Attendance for Extraction under Anæsthetics		1410
,, ,, without ,, ...		768
Total		3786

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Arthur Durham Memorial.

DEAR SIR,—We are sure that as an old Guy's man you would desire that steps should be taken to perpetuate the memory of Arthur Edward Durham in association with the Hospital and Medical School to which he devoted the best years of his life and work. The particular form which such a memorial should take has been a matter of careful consideration, and with the full assent and approval of his family it has been decided that at the present time, when the finances of the Hospital are so seriously embarrassed, the best tribute which can be paid to his memory is the endowment in perpetuity of two beds—one in each of his old wards, Lazarus and Martha—to be called the Arthur Durham Beds.

For this purpose a sum of £2,000 will be requisite. In appealing to all Guy's men and to other friends for liberal subscriptions towards this worthy object it is needless for us to dwell upon the manifold services Mr. Durham rendered to Guy's as a teacher and surgeon of the first rank, upon the unaffected kindness of his disposition, and upon those genial traits of character which endeared him to all who had the privilege of knowing him.

Contributions should be paid to Mr. C. H. Wells, at the office of the Medical School, and they will be acknowledged from time to time in the GUY'S HOSPITAL GAZETTE. In the belief that many will be glad to possess such a memento, it is proposed to present subscribers of One Guinea and upwards with a platinotype enlargement of what is regarded as the most life-like photograph of Mr. Durham, in a form suitable for framing.—We are, dear Sir, yours faithfully,

(Signed) E. H. LUSHINGTON, Treasurer.
P. H. PYE-SMITH, Senior Physician.
H. G. HOWSE, Senior Surgeon.

Guy's Hospital, June 5th, 1895.

Pass List.

Royal College of Surgeons of England, May, 1895.

FINAL EXAMINATION FOR THE FELLOWSHIP.

Harris, W. J. Shillitoe, A.
Stevens, T. G.

University of London, May, 1895.

M.B. PASS EXAMINATION.
SECOND DIVISION.

Elliot, W. H. W. Richmond, B. A.
Steinhaeuser, J. R.

Pus; its cost.

THAT pus should be a commodity having any pecuniary value may seem a strange fact to some of us; but that it has a price, and in some cases a pretty high one, has been brought to my notice pretty forcibly of late. I do not wish to bring up instances of those terrible calamities in which the infection of large joints, or the peritoneum, has resulted in the death of the patient, or even those cases in which the ensuing ankylosis of a joint has deprived the individual from henceforth satisfactorily following his employment; the evils of such are patent to every one. Rather do I allude to those more minor occurrences, which are ofttimes looked upon by those who perform and take part in operations as of minor importance only, but where investigation shows that the subsequent and far-reaching results are most serious to the patient.

Perhaps no one would call the following case trivial; but as it forms a good instance of what I wish to point out regarding these after consequences I mention it here.

A young and healthy labourer was admitted into a country hospital suffering from a crushed leg. Amputation was thought advisable, and performed, "skilfully enough be it said," through sound tissue, well above the injured part. The antiseptic arrangements, however, were carried out in a somewhat casual fashion; the result was, that in a few days' time pus began to ooze out from between the flaps, and in a fortnight, instead of there being a clean healthy stump, there was a yawning chasm, from the depths of which stinking pus poured out profusely. The man, however, eventually got well, and left the hospital with a fair stump, and, perchance, so far as the limb was concerned, he was not so much the worse off for his suppuration; but—and now comes the point to which I draw your attention more particularly—What about the result of the extra time that he had spent in bed, and was incapable of doing anything, instead of being able to go out in about eight weeks, and do some light job—say, as a watchman or timekeeper—he was in for four months, and at last when he did get out, shattered by the drain upon him, 'twas only to find that his wife had been forced to pawn the contents of their home, and with their couple of children had to seek refuge in the poor-house? A dear price to pay, surely, for what ought never to have happened.

Now, again, let us take the case of John Smith. He was a horse-keeper, and afflicted with a rupture for which he desired a truss, but the advantages of an operation having been put before him, he decided upon having it done; with this object he obtained from his master a month's leave, upon the understanding that he was to be back at the expiration of that time.

Alas for John Smith; a month saw him still an inmate, with a raw patch, a sinus, and a drachm of pus per diem. He went out in seven weeks, but some one else was grooming his horses, and, what was worse,

taking his salary, so John Smith had to depend upon that unstable support, "the charity of his friends."

These are not isolated cases, for I am sorry to say that I know of many such.

Considering the great importance, as shown by the above, of the results which might accrue from even the slight infection of wounds, and the fact that their prevention lies entirely in our own hands, it is a scandalous thing that operation wounds get infected in the way they do, and I fear that this is due, however surprising it may appear, to the fact that many of those who perform and take part in operations are ignorant of the elements of this, perhaps the most important part of surgery. I say the most important, because, before a surgeon cuts into human tissues he ought to do so with almost a full certainty that the wound he makes shall heal up, without any untoward result to the patient who has placed himself in his hands; until that is so, all refinements, such as how you should cut, what sutures one should employ, or what length should be left, are but the merest side issues.

If through negligence or want of proper precaution a man is injured at work, his employer is liable for the damage sustained. We in the medical profession, however, have no Government inspector to enquire into our treatment; if a wound does go wrong we are not brought to account, for the unfortunate patient, ignorant of technical details, cannot know that some one has blundered. To him suppuration in a wound may appear the proper method of healing. We are answerable, as it were, to no one, and if that were the only reason, we ought surely to do our utmost to deserve that unquestioning confidence.

Accidents may happen occasionally, even under the strictest precautions—of these one says nothing—but the casual and perfunctory way in which asceptic details are but too frequently carried out calls for the strongest condemnation, and ought to render the offenders liable to a criminal prosecution.

D. M. B.

Short Sayings of Great Men.

The Three Professions.—The *Lawyer* sees men at their worst. The *Clergyman* sees them at their best. The *Doctor* sees men as they really are.

The Lecturer on Anatomy: "What is the best instance of the calcification of tendons?" "An old pheasant."

A medicinal game.—Oranges and lemons.

KINGSLEY PERVERTED.—Clerk (persistent enquirer after "Truth"): "Is it not extremely rare for that symptom to be present in this case, sir?"

Physician (condescendingly, not budging an inch from his diagnosis): "Well,—yes,—it can't be helped. If it ought to be, it will be; if it is, it ought to be!"

Introductory Lecture to the Course on Materia Medica and Therapeutics.

DELIVERED AT GUY'S HOSPITAL, MAY 5TH, 1874,

BY W. MOXON, M.D., F.R.C.P.,

Physician to the Hospital.

(*Continued*).

One blushes all over to belong to the same craft, and gladly rests one's sight again on the noble forms of the Imperial Roman and the Greek beyond. It is, indeed, incomprehensible to us at first sight how such views could be entertained. In justice, if not charity, to those who enacted such abominations, it would be fair to look at the causes that impelled them. But time presses, and I would not go farther on this topic but that we should consider whether such causes are quite inoperative now, and whether we and our successors are safe from their action; for the climax of rational purity in our time will inevitably prove another wave-summit, and the trough time must come again. Let us for a moment put ourselves in the place of a seventeenth-century-doctor, and realise the circumstances in which he lived, and especially the knowledge he had to share. Recollect that the leading and active minds of that age believed in witchcraft and fairy influence, not in a vague and dreamy sort of way as a few weak people hold a similar spiritual view now a days, as a pleasant means of encouraging a dull imagination, but they believed that there actually were some sorts of subordinate spiritual agencies who could make tangible things move at their will, and they believed that these spiritual agencies were subject to the influence of spells and charms, so that signs and dodges would bring them into play. They confidently knew that nasty things, like toad's flesh and crab's eyes, or queer actions, like gibberish and grimaces, would effectually overcome physical obstacles. Now we know that, within the range of accurate experience, the influences under which physical changes occur are not erratic. In other words, spiritual powers are orderly so far as they touch physical nature, and any impulsiveness or waywardness, men, imperfectly understanding each other and the whole subject, compel each other to acknowledge, belongs to the world of the soul where the light is not that of the sun, and things with shapes are not subject to gravitation—a world as much within our experience as the other, and by the physician never to be under-estimated, since it is at the points of contact between it and the inert matter within his patients' bodies that his problems are of the greatest importance and interest. His problems perhaps more often concern the immaterial than the material part of the patient, and his tonics are often most efficient there.

But try to realise the time when the best people, confusing the truths of the material and immaterial world, allowed a belief in witchcraft, and think what then would be the mental state of common people. It is worth thinking of; for remember that, if the course

of humanity move in waves like the sea, it is only the higher and greater that feel the lift of the wave and catch the light it reflects; deeper down is a sluggish mass that is untroubled by the action above. Look about you and try to estimate the way of thinking of the low people of our own time on anything that does not touch their bread and cheese. Nay, do not wonder virtuously; look within and see yourself fairly; for, though in broad daylight, when you are pretty well and happy, strong-headed and stout-hearted, all things seem established like the hills, and orderly like the stars, yet, if you be not very well, or if it be murky twilight, and the wind howl, and somebody be recently dead next door, it does not take much to make your flesh creep a bit; so that all things take more their tone from the uncertain clouds, calamitous tides and earthquakes, unaccountable blights and shocking accidents, entirely beyond the regulating power of the most diligent and conscientious Board of Railway Directors. So do not think yourself out of reach of superstition, and especially do not think your patients out of its reach. See how credulous and weak, in time of family sickness, is even that doctor who has carried scepticism beyond due bounds. Of course, he will afterwards say it only shows that he was all afloat at the time. But let this show what you are to expect from those who are similarly at sea, but who have never taken in a ballast of medical earth-knowledge. In viewing the superstitions of past centuries, you must recognise that the world does not essentially change from age to age. When you trace any feature common to bygone times, you should find out what it is that corresponds to it in your own. Do not be led by the rational atmosphere at this hospital to think the world is led by reason. Do you think that charms and spells are effaced, and that people do not hold to and long for them? Do not make such a mistake; they have not departed at all, nor been done away; they have only a little changed their shape, and are recognised without much difficulty. You will find the old and natural trust in spells and unknown agencies to be embodied, often very plainly, in the faithfully exact and almost worshipful deglutition of the orthodox dose three times a day. You may know it is only ammonia and gentian. They may half know it. But never think they take it as they would take a "pick up" of brandy and soda: they swallow it as if to Æsculapius, and in the gulp their eyes sparkle with all the old ineffaceable longing for help from the unknown. The time-honoured potion carries with it the undying power of the medicine-gods and medicine-man, of Fairyland, and of the witches, as real as ever. The conditions of emotional overstrain and tendency to unwonted credulity are naturally present around the sick-bed, and often are the more urgent in proportion as the occupant of it is more beloved. The calamity came from the unknown, and they will have help from the unknown. No education or civilisation will ever refine or develope them out of that, for education and civilisation carry nature farther, while it remains the same as before. This insatiable demand on unknown forms of help keeps therapeutics unstable. The demand from the unknown is answered, and the -opathies come out of limbo hungry, but smiling and full of promise, and patients encourage and favour their mysterious aid, and are ready to believe that what they have taken produced all the feelings that happened since, and hope made these feelings more pleasant. Thus pretentious quackery thrives parasitically on the sufferer's faith and hope.

I venture to spend your time in this generalising way instead of endeavouring to attract your attention to the very ingenious and amusing experiments upon the action of drugs on protoplasm, because I know that it is as to the wider scope of therapeutics that you are in danger of being beaten by unworthy competitors when you go into practice. It is in the greater care they give to the circumstantial and dietetic management of the sick, that homœopaths and other quacks succeed better than some upright practitioners. When people go wrong into homœopathy, and so on, there is always some explanation of it. They mean in this, as in other things, to be as right as is conveniently possible; and, if many of the currently so-called intelligent fall under homœopaths, we should know the reason of this. A part of it is, doubtless, the longing for mystery of which I have just spoken. So far, they are willing dupes, and you cannot help them, and can scarce pity them, deceived as they are, for some easy, advantageous, or pleasing process or result. There may come to mind one of Carlyle's best sayings, to the effect that a dupe is a rogue downside up; this is one of the truest things speakable, though, in our context, it verges almost on the unspeakably true. But you cannot believe that any such cause will explain a great part of such prevalence of homœopathy as has been witnessed. Indeed, gentlemen, the width and blackness of this disreputable blot on modern medicine is due, no doubt, to the narrow scope to which therapeutical science allowed itself to be limited formerly under the influence of theoretical systems, as pretentious and vain as homœopathy, but much more dangerous: systems, in which violent measures in medicines and surgery were used, without mercy, and almost without reflection, while the vast influences of wise nursing care were neglected; so that no one knew when a medicine had real efficiency, when it was necessary, and when useless or hurtful. But now, thanks to the originators of the medical press, a means has been found in it whereby the experience of observers can be compared, and medicine is no longer so dependent on the authority of enthusiasts. A common sense arises against the quackery of systems; and thus, gradually, a balanced and stable system of truly rational medicine is formed, founded on careful observation of cases, and unpretending attempts at cure correctly recorded. No doubt there is room for improvement now, and we are witnessing a tendency to force the drug-medicines by publication, by men in good position, of results which the experience of other observers does not support.

But, though such cures of chorea and boils, and so on, may serve their publishers' purpose, medicine is not much hurt, for other people can correct the wrong statements; and, spite such a gentleman's surprising cures, the world will come soon and commiserate with him on the perversity with which fate, usually so equitable, seemed set to force on him the delusion that his plan was better than others; or will grandly let him go unnoticed, and even let him take with him, as far as he can, the little he gets by it, perhaps not quite suppressing a certain smile at the one who goes glibly by with much benefit from his advertising gallipots of pancreatic filth.

The practical object of the remarks I shall have to address to you, in the course of the next three months, will be to give you a useful critical knowledge of the powers of really powerful remedies. It will be my official duty to make you acquainted with a deal that will not come under that description; and I must crave your patience and sympathy when that may appear too obvious to you. Now, at medicine lecture, a large part of this is put before you very ably, but from a point of view regarding primarily the diseased states, in some order which is founded on the diseases in their mutual relations. Such a mode of consideration makes it seriously likely, that many of the powers and uses of the medicines themselves may escape your notice; for the several kinds of help, which different remedies can give, are so scattered about in the history of medicine, and hit upon hence so casually, that a clear notion of the special services of each could not be directly acquired in such a line of study. You want to take the several drugs that have any real powers; then to know something about them which shall, as far as possible, explain their efficacy; and then to learn well the powers they have, and what disorders they are fitted to relieve, especially any peculiar use of the drug which experience may have brought to light; the last being, in my opinion, the most practically important knowledge, but only tolerable when based on the former. I said that, at medicine lecture, the consideration of the diseases is the primary consideration, and the consideration of their treatment follows. As a consequence of this, the order of proceeding in medicine is based on the method of considering diseases. The question the medicine lecturer asks is, "What is good for this?"

But we have to take up the drugs and ask "What is this good for?" so that we, on our part, must find some line of procedure, having a proper regard to the mutual relations of the drugs. And that forces us to select some class of these relations for the purpose of determining our line of progress. But, as we do not want to cut a figure in the march, but to have a good property at the end of it, we shall not consider the settlement of the sort of relations that shall guide us as a very vital question; which is fortunate for us, since it is a most debateable question. Very debateable questions, you know, must always be settled by will. Still, as the inquiry is capable of clear principle, we will look at it for a moment. Remedies are objects or forces which already are subject to classification in their several natural places; electricity, heat, etc., among the "modes of motion"; minerals, plants, and animal products in the works on chemistry, botany, and zoology or comparative anatomy. Now we may keep them in this their usual scientific order; and this plan is usually adopted in works on materia medica. It is a plan I should employ without hesitation if I were a chemist and druggist. But we are users, and our function is not to store or sell drugs; and hence we will class them, so far as we class them at all, according to their uses in the cure of disease. But what is cure? Perhaps the vulgar notion of cure is very much this. They seem to suppose that the drugs would fit diseases in a perfect way, if we only knew it. They apparently believe that if the stocks of the chemists' shops could at once be properly distributed in the bodies of all sufferers, a balance would be struck, and then and there all human illness would come to a happy end. An individual, in this belief, goes into a chemist's shop, and, as he looks at the bottles in bright array there, thinks that in one of them is that by which he might live; just as you may go into our museum of morbid anatomy, and, among all the bottles, know there is that in one of them of which you will die. But directly you, as a doctor, forsake this vulgar notion of cure, and enter on the question of relieving any diseased state, forthwith your intention finds itself opposite a division of the line ahead. For two aims present themselves: one is, to know what causes the disease, and to meet its causes by the light of that knowledge; the other is, to recognise the disease as one for which a cure is already known, and to use the cure at once.

(To be concluded.)

Calendar of Coming Events.

June 8th—Guy's Bicycle Club. Meet at Marble Arch, 3.30 p.m. for Oxford.

" 11th.—Guy's Rifle Association v. Harrow.

" 12th.—1st XI. v. Brentwood, Brentwood.
2nd XI. v. Dulwich College II., Dulwich.
Guy's Bicycle Club. Run to Richmond. Meet at "Plough," Clapham.

" 13th—Guy's Christian Union. Three short addresses by members.
Guy's Rifle Association. Practice, Ilford.

" 15th—1st XI. v. Eastbourne, Eastbourne.
2nd XI. v. Whitgift Wanderers II., Honor Oak Park.
Guy's Rifle Association v. R.I.E.C., Cooper's Hill.
Guy's Bicycle Club. Run to Digswell Hill (Inter-Hospital).

" 18th.—First XI. v. Croydon, Croydon.
Guy's Rifle Association. Prize Competition, Ilford.

" 19th.—United Hospitals Athletic Club Meeting.
Guy's Bicycle Club. Run to Bexley. Meet at "Greyhound," Dulwich.

Notes from the Dispensary.

ALOE BARBADENSIS ET SOCOTRINA.—In the forthcoming edition of the British Phamacopœia, the derivation of some of the organic drugs will require modification. Students of Materia Medica learn that there are two kinds of Aloes, Barbadoes from Aloe Vulgaris, and Socotrine from Aloe Perryi. At the present time very little real Barbadoes Aloes comes into the drug market, and the Aloes from Socotra seems now to exist only as museum specimens. Of late years Barbadoes Aloes has been replaced by a pale Curaçoa variety, and the commercial article now known as Socotrine agrees in its reactions with Barbadoes Aloes, and must be attributed to some species of Aloe Vulgaris and not Aloe Perryi.

Aloes has an interesting history. It was known to the Greeks as a production of the island of Socotra as early as the fourth century B.C. There is a remarkable legend occurring in the writings of the Arabian geographer Edrisi regarding Aloes and the island of Socotra, which relates that when Alexander had conquered the King of the Persians and his fleets had vanquished the islands of India, and he had killed Paur, King of the Indies, his master Aristotle recommended him to seek the island that produces Aloes. So when he had finished his conquests in India, he returned by way of the Indian Sea into that of Oman—conquered the isles therein and arrived at last at Socotra, of which he admired the fertility and the climate. From the advice which Aristotle gave him he determined to remove the original inhabitants and to put Greeks in their place, enjoining the latter to preserve carefully the plant yielding Aloes, on account of its utility, and because that without it certain sovereign remedies could not be compounded. He thought also that the trade in and use of this noble drug would be a great advantage for all people. So he took away the original people of the island of Socotra and established in their stead a colony of Ionians, who remained under his protection and that of his successors, and acquired great riches, until the period when the religion of the Messiah appeared, which religion he embraced. They then became christians, and so their descendants have remained up to the present time (circa A.D., 1154).

It may be inferred that the use of Aloes was not unknown in Britain as early as the tenth century. There are notices of it in the Anglo-Saxon leech-books, and a reference to it as one of the drugs recommended to Alfred the Great by the Patriarch of Jerusalem. At this period and for long afterwards the drug was imported into Europe by way of the Red Sea and Alexandria. In the early part of the 17th century there was a direct trade in Aloes between England and Socotra; and in the records of the East India Company there are many notices of the drug being bought of the "King of Socotra." Frequently the king's whole stock of Aloes is mentioned as having been purchased. Wellstead, who travelled in Socotra in 1833, says that in old times Aloë was far more largely grown there than at present. He adds that the produce was a monopoly of the Sultan of the island. At the present the few productions of Socotra that are exported are carried by the Arab coasting vessels, coming annually from the Persian Gulf to Zanzibar, at which place they are transhipped for Indian and other ports.

Barbadoes Aloes appeared in the drug warehouses of London about 1693. Ligon, who visited the island of Barbadoes in 1647–50, that is about twenty years after the first settlers, speaks of the Aloë as if it were indigenous, mentioning also the useful plants which had been introduced. At that period the settlers knew how to prepare the juice for medicinal use but had not begun to export it.

Aloes was formerly used externally in the treatment of wounds and languid ulcers, usually in combination with some balsamic substance. Tinct. Benzoin Co. contains Aloes, and represents the old Wound Balsam, Jesuits Drops, and Friar's Balsam of byegone days. The value of Aloes as an external application does not now seem to be appreciated, for it is proposed to omit the Aloes from Tinct. Benz. Co. in the new British Pharmacopœia.

It is interesting to note that Aloes is used and sold largely as an emmenagogue. The formula still employed is the ancient Hiera Picra (Pulvis Aloes cum Canella, London Pharmacopœia, 1746). It is commonly called Hike Pike.

BISMUTH SUB-NITRATE AND THE TEETH.—The Subnitrate of Bismuth is chemically a basic, but practically an acid salt. It can be shown by experiment that this compound will dissolve marble, but that the Bismuthi Carbonas has no action whatever. Particles of Bismuth Subnitras lodging about the teeth would probably have an injurious effect upon them. Therefore, from a dental aspect, the Bismuthi Carbonas is the preferable salt.

H. COLLIER.

Guy's Hospital Clubs' Union.

REPORT FOR THE YEAR ENDING MAY 31ST, 1895.

IN presenting the third Annual Report, the retiring Council would wish to express their very deep sense of regret at the loss which all Guy's men have sustained by the death of their first President, Mr. Durham, whose warm interest and constant help did so much to promote the formation and success of the Clubs' Union, and whose retirement from the Council was deplored in the report of last year.

The ground at Honor Oak Park, under the charge of Harris, the ground-man, is in better condition than at any previous time. The discovery of a fault in the drainage has led to a material improvement in the Association Football Ground. The levelling that has been carried on during the winter has resulted in a large new area being available for tennis courts; and evidence of the satisfaction which these improvements

have afforded to the members has been furnished by the larger number of railway tickets which have been used.

The vitality of the Union is proved by the number of members, which has increased to 1,521, of whom 1,192 are life members, about 300 annual subscribers, and 29 patrons, and the Council wish again to thank the numerous patrons and old Guy's men who, by their subscriptions and active interest, have supported the Union.

The ground was selected last summer by the United Hospitals Cricket Club for the Inter-Hospital matches. A Guy's Nurses' Lawn Tennis Club has been lately started, the members of which use the ground on three mornings in each week.

All the original institutions are in a flourishing condition, and two new ones (the Debating Society and the Rifle Association) have been admitted to the Union.

The thanks of the Council are tendered to the auditors and to the officers of the constituent institutions.

A statement of the receipts and expenditure during the last year is appended.

In conclusion, the Council have to report that their successors have been duly elected in accordance with the rules of the Union, and that the following are the names of the new Council:—Drs. Pye-Smith, Taylor, Shaw, Bryant, Messrs. Brailey, Fripp, Bell, Collins, A. B. Carter, K. B. Alexander, Hamblin Smith and E. J. Spriggs.

(Signed) P. H. PYE-SMITH, President.

STATEMENT OF RECEIPTS AND EXPENDITURE FROM 1ST APRIL, 1894, TO 31ST MARCH, 1895.

1894—April 1. RECEIPTS.	£ s. d.	£ s. d.
To Balance at Bankers	92 6 10	
„ „ Petty Cash in hand	1 2 6	
		93 9 4
1895—March 31.		
To Subscriptions and Donations from 1st April, 1894, to 31st August, 1894	422 15 0	
„ ditto from 1st September, 1894, to 31st March, 1895 ...	1078 16 0	
		1501 11 0
„ Grant from Medical School		100 0 0
„ „ Dental „		10 0 0
„ Rent from Tenants		60 10 0
„ „ Lockers		0 17 6
„ Blue Book Advertisements		18 11 0
„ Gate Receipts		22 1 6
„ Sale of Railway Tickets		45 8 8
„ Balance of Physical Society—Grant repaid		4 13 4
„ Deposit Interest		0 10 1
		£1,857 12 5

1895—March. EXPENDITURE.	£ s. d.	£ s. d.
By Grants to Constituent Institutions—		
Athletic Club	45 18 6	
Bicycle Club	5 0 0	
Cricket Club	22 10 0	
Football, Association ...	13 10 0	
„ Rugby	22 0 0	
Gazette Fund	288 5 0	
Physical Society	28 10 0	
Prayer Union	7 0 0	
Reports Fund	273 15 0	
Rifle Association... ...	10 0 0	
Students' Club	297 17 10	
Tennis Club	27 1 0	
		1041 7 4
„ Field—Current Expenses		359 7 0
„ „ Rent Account		234 10 0
„ Management Expenses—		
Printing and Stationery...	78 11 7	
Secretarial Expenses ...	48 11 9	
Postage, including special letters	20 13 11	
		147 17 3
„ Gate Expenses		5 4 0
„ Railway Tickets Deposit Account ...		62 2 0
„ Petty Cash in hand	1 2 6	
„ Balance at Bankers	6 2 4	
		7 4 10
		£1,857 12 5

Examined and found correct, May 16th, 1895,

(Signed) L. A. DUNN.
H. A. MUNRO.

An Aseptic Thermometer Case.

WE have received from Messrs. Hills & Co., of Newcomen Street, a thermometer case, the outcome of an ingenious suggestion made by Mr. H. T. Hicks. To an ordinary case is fitted at one end an india rubber ball, which can be filled by means of a pipette with some antiseptic solution, such as carbolic acid lotion. The cap over the ball is to prevent its being pressed upon when the case is carried about. The chief advantage claimed for this clinical thermometer case is that the thermometer can be disinfected after use, without having to carry the carbolic acid lotion separate. The solution does not run out unless the ball is squeezed, which is best done by holding the case sideways. The idea is distinctly original, and although hardly sufficient time has been afforded us to thoroughly test its efficiency as a germ-destructor, we have no doubt that Mr. Hicks' invention will be of considerable convenience and usefulness to general practitioners.

Recent Additions to the Hospital Library.

Erichsen's Surgery. Latest Edition.
Bernthsen's Organic Chemistry.
Burney Yeo's Medical Treatment.
Coate's Pathology.

"Science Progress" is now included in the list of magazines received in the Library.

PRESENTATIONS.

By Dr. Stevenson—
Harveian Oration for 1894.
Husband's Forensic Medicine.

By Sir T. Dyke Acland—
Unveiling the Sydenham Statue.

By the Secretary of State for India—
Bellew's History of the Cholera in India.
Bellew's Treatment of Cholera.

By the Secretary of State for War—
Report of the Army Medical Department for 1893.

By Baillière, Tindall & Cox—
Campbell Black's Urine and Urinary Analysis.
Tables of Doses and Strengths.

Bale & Sons—
Sutherland's Difficulties of Prognosis in Insanity.

Cassell & Co.—
Year-book of Treatment for 1895.

Griffin & Co.--
Davies' Handbook of Hygiene.

H. K. Lewis—
Schimmelbusch's Aseptic Treatment of Wounds.
Swanzy's Diseases of the Eye. Fifth Edition.
Kelynack's Pathology (Pathology of the Vermiform Appendix).
Boxall's Introductory Lecture at Middlesex Hospital for 1894.
Crookshank's Prevention of Small-pox.
Tomlin's Droitwich Brine Bath.
Rolleston and Kanthack's Morbid Anatomy.
Dührssen's Gynæcology.
D'Arcy Power's Surgical Diseases of Children.

Macmillan & Co.—
Kanthack's Practical Bacteriology.

Scientific Press Co.—
Burdett's Helps in Sickness.

Swan Sonnenschein & Co.—
Vine's Text-book of Botany.

Whittaker & Co.—
Brodie's Dissections. Illustrated. Part IV.

Wright & Co.—
Fenwick's Urinary Surgery.

Sport.

Cricket.

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

Played at Honor Oak Park on Saturday, 25th May. Owing to the brilliant display of batting on the parts of Wetherell and Clarke, the Second XI. have two easy victories to record this time. Two centuries in one week is well worth recording. Team:—

De Coteau, lbw, b Harrison	37
F. C. Wetherell, not out	137
C. T. Anderson, lbw, b Harrison	0
G. R. Levick, not out	40
F. E. Walker, H. Durbridge, H. Bignold, H. Barrow, M. Thornely, B. Onraet, E. Shorland, did not bat.	
Extras	22
Innings declared closed. Total	236

ST. THOMAS'S.

B. L. Storrar, b Anderson	13
P. R. Browning, b Wetherell	0
A. R. Howse, c Thornely, b Levick	44
W. Ashford, b Wetherell	6
J. T. Prain, b Wetherell	3
J. Glasgow, b Durbridge	0
S. D. Turner, b Wetherell	2
H. Harrison, b Wetherell	1
A. Jones, b Wetherell	20
Cunningham, b Walker	5
Dudgeon, not out	4
Extras	12
Total	110

GUY'S 2ND XI. v. PLEYDELL.

The latter winning the toss, very kindly took the field, and so gave the home team every chance. Team:—

GUY'S.

A. E. Clarke, not out	163
C. T. Anderson, b and c Moat	7
E. G. Goddard, c Moat, b Canham	0
L. Humphry, c Collins, b Bell	8
E. D. Hancock, b Bell	0
N. Lavers, not out	6
De Coteau, H. Bignold, K. Morgan, M. Thornely, R. Barron, did not bat.	
Extras	22
Innings declared closed. Total	206

PLEYDELL.

Dick, b Hancock	5
Lee, b Hancock	6
Collins, b Hancock	1
E. Bowyer, b Clarke	1
Canham, c Lavers, b Clarke	19
Rodgers, b Clarke	1
Bell, b Clarke	4
Moat, c De Coteau, b Hancock	1
Foreman, b Anderson	10
F. Bowyer, run out	1
Fuller, not out	0
Extras	23
Total	72

Birth.

PARE.—On May 21st, at 18, Portland Place, W., the wife of J. W. Pare, M.D., C.M. Edin., L.D.S. Eng., of a son.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette.

JUNE 22, 1895.

Three Common Causes of Jaundice.

CLINICAL LECTURE BY DR. SHAW.

FIRST let me give you brief abstracts of the reports of three patients now in Clinical, each of whom presents the symptom jaundice in a more or less marked degree.

I am glad to have the opportunity of contrasting them, because these three cases are examples of the three commonest causes of jaundice—causes which should always occur to you as probable in any case which presents itself for diagnosis, and which must always be carefully excluded before you proceed to hazard an opinion that you have one of the rarer conditions to deal with.

These three great causes are gall-stones, cirrhosis and cancer. I have not attempted to put them in the order indicating their relative frequency, because this will vary according as the cases present themselves in the post-mortem room, in hospital, or in general practice.

The order in which they are placed indicates the gravity of the prognosis in the three conditions.

(*a*) *The Gall-stone case.*—A woman, æt. 49, having had perfect health till six months ago was then suddenly seized with violent pain, causing her to be doubled up and producing vomiting. Shortly afterwards her husband noticed that she had yellow jaundice. Since then, attacks of pain, lasting about 48 hours, have recurred at short intervals; the period of freedom from pain generally being eight or ten days. After each attack the jaundice becomes more intense, passing off somewhat during the interval. Sometimes her motions are white. She was admitted on a Monday, a few hours after the cessation of an attack of pain which commenced on the preceding Friday. She was found to be considerably jaundiced, and to have a smooth general enlargement of the liver. The gall-bladder could not be felt. It is now more than fourteen days since her last attack. The jaundice is subsiding and there has been no recurrence of the pain.

(*b*) *The Cirrhosis case.*—A publican's wife, æt. 31, who helps in her husband's bar, states that she has never been intoxicated, but has "taken a little gin and milk every morning, a little brandy whenever she has been faint, and lately they have had a cask of champagne." Her definite illness began four months ago with menorrhagia, attributed to a fall, since which time she has generally been laid up. Six weeks ago she became "as yellow as a guinea." Her motions have not been white, but her urine has been very dark. On admission, she is decidedly jaundiced, of a bright yellow hue. The liver is enlarged, its edge being hard and sharp. The gall-bladder cannot be felt. Soon after admission she developed a mild attack of delirium tremens, so that she was transferred to the solitary ward. There are some symptoms of commencing alcoholic neuritis.

(*c*) *The Cancer case.*—A man, æt. 47, who suffered from English cholera 20 years ago, and during the succeeding ten years had attacks about once in three months of what he calls cramps in the abdomen, in which he would be doubled up with pain and would generally vomit.

These attacks have not occurred during the last ten years, and he has been well till two or three months ago when he suffered from a milder and more constant abdominal pain, associated with loss of appetite and sleeplessness. Five weeks ago he became jaundiced, his urine became dark coloured and his motions, to use his own expression, "were a little lighter in colour than oatmeal." There has been no loss of blood from the stomach and bowels and no serious interference with digestion or defæcation. He has lost one stone five pounds during his illness.

On admission, he was very deeply jaundiced, and when I first saw him some days later, of a distinctly greenish tint. His liver was greatly enlarged, and equally so, except that a rounded swelling was detected near the umbilicus, which was thought to be the distended gall-bladder. It was felt to be somewhat uncertain whether the obstruction was due to gall-stones or cancer, and to make sure and to remove the obstruction if possible should it turn out to be a gall-stone, an exploratory laparotomy was undertaken. Deposits of growth were felt on the surface of the liver and around the neck of the gall-bladder; no gall-stone was felt and the wound was closed.

A good deal of ascitic fluid escaped at the operation, and since that time a considerable re-accumulation has taken place The wound healed rapidly, and the patient is in much the same condition as when he came in. Had this last case come under observation for the first time at a somewhat later date, so that the ascites found at the operation had been in sufficient quantity for its recognition by palpation, there is no doubt that gall-stones as a sole cause of the condition would have been excluded and the diagnosis have been almost as easily made without an exploratory operation as in the two cases I have already related to you. But in case you should feel that the differential diagnosis of these conditions is too simple to deserve your most serious attention, I would remind you of a case the autopsy of which many of you must have lately seen. The case was one of cancer of the duodenum, obstructing the biliary papilla, the patient having been in Clinical ward for many months in the last two years. I am not sure that a correct diagnosis was reached before the patient's death, but I believe that of the various physicians who took charge of the ward, one at least could have been found at different stages of his illness to defend, with more or less confidence, each of the three diagnoses, gall-stones, cirrhosis and cancer.

But now to turn from the particular cases to the general principles that have been called into our service to aid us in determining their nature. There is in all these cases the essential fact that the patient is jaundiced. This is a diagnosis that patients generally make with sufficient accuracy for themselves, and, unlike many conditions which the laity can recognise, it is not considered sufficient for the medical man to translate it even into Greek. Easy as is the diagnosis of jaundice generally, mistakes are sometimes made, though perhaps in this particular condition there is some excuse for the candidate who, when asked from what a certain disease might be mistaken, replied to the examiner, "It depends upon how stupid you are." It is not, therefore, because of the inherent difficulty in the diagnosis that I shall draw your attention to the main sub-symptoms which make up the symptom jaundice, but because these sub-symptoms vary in themselves according to the cause of the jaundice. I shall, however, take the opportunity as we proceed to indicate where the careless person may fall into error. Having to deal with a secretion possessing so deep and distinctive a colour as the bile, it is not surprising that our first means of recognising its undue retention in the blood is dependent on the existence of the colouring matter in places where it should not be, and its absence from places where it in health normally exists. Its presence in the skin is the point upon which the lay diagnosis practically rests. We only amplify this by noticing that it is more marked in the face and upper part of the body than it is in the legs, and that it is more easily discernible in mucous membranes that are pale than in those through which the red colour of the blood is plainly visible. The laity are often able to distinguish between what they call the *yellow* jaundice and the *black* jaundice, and the profession recognise that in long-standing cases of complete obstruction the bilirubin becomes oxidised into biliverdin and produces the olive green tint which was once thought to be pathognomonic of malignant disease, and is now known only to be much more commonly due to cancer than to any other cause, because cancer is the cause which when once established produces the most constant and most intense form of jaundice.

It is only when this yellow colour of the skin is slight that a careless observer may mistake the lemon-yellow tint of pernicious anæmia or a mere sallowness of complexion for jaundice. He would be saved from this error if he remembered that when jaundice produces

yellowness of the skin it will produce an equal yellowness of the conjunctiva, and that this membrane being spread out over the white sclerotic, reveals its alteration in colour much more distinctly than does the already somewhat yellow skin. Let him not forget, however, that the subconjunctival fat is yellow, and avoid mistaking this for a jaundiced eye by noting the irregular distribution of the fat, which is always in greatest quantity along the line of the palpebral aperture.

Among the fluids of the body which show this abnormal pigment remember the urine, the sweat, the milk, and the humours of the eye, and note the contrast with secretions such as saliva, succus entericus, and the mucous fluid poured out into the gall-bladder and bile-duct, which in the most advanced cases are entirely free from any yellow colour.

The change in the colour of the humours of the eye sometimes leads patients to "see yellow." The patient with cancer is stated to do so. It is easy to understand how a patient may fail to notice this himself, as any of you may recognise who have worn blue glasses for reading or mountaineering. In investigating a subjective symptom such as this, it is often difficult to assure one's self of the accuracy of the patient's observation. The most convincing case I have seen was a man who, on being asked in the out-patient room if he had been more yellow than he was at the moment, said, "O yes; last week I was as yellow as that," pointing to a sheet of bright *red* blotting-paper. It is the urine, however, that will be of most service in diagnosis, for by the appropriate chemical tests which I need not here specify the smallest quantity of bile pigment may be detected. It is well to remember that it is stated that in cases of sudden obstruction of the ducts bile will appear in the urine before it appears in the skin, while, on the other hand, if the obstruction be removed, the urine may be found free from bile some days before the skin assumes its normal tint. Equally striking is the absence of the colouring matter from the fæces, which, according to the completeness of the obstruction, may lead to all gradations of colour, from the normal to the absolutely white motions which are so inappropriately termed clay-coloured. Inappropriately, I say, because the colour of clay, in my experience, is no more definite than the size of a lump of chalk. Please remember that this white colour is probably partly produced by the greater amount of fat contained in the fæces, and that it may undoubtedly, as Bright pointed out, be observed in cases in which bile pours freely into the duodenum, if there is at the same time complete obstruction of the pancreatic duct.

To obtain a complete picture of jaundice we must use other senses besides our sight. We must observe the slow pulse, sometimes reduced to 20 in the minute, we must listen to the patient's tale of the intolerable itching, objective evidence of which we often notice in the papular rash produced by the finger nails in all accessible situations. The patient may tell us of indigestion, a bitter taste in the mouth, troubles with the bowels, generally in the direction of constipation, and of the consequent headache and general feeling of malaise. Lastly there may appear those symptoms of such serious import which are generally called *cholemia*, and which consist of slight delirium and drowsiness, passing on into a fatal coma.

The most scientific method of approaching the second part of our subject would be to point out the way in which the three causes differ under the following heads, and trace the resulting difference in the symptoms. It is clear that if there is variation of the symptoms the variation must depend upon:—

The completeness of the obstruction:

The situation of the obstruction:

The permanence of the obstruction;

and that other symptoms will be present or absent because the lesion which produces the obstruction does or does not interfere with the structure or functions of the body in other ways than by producing obstruction. Although we shall bear these points in view, it will be more practical and useful to approach the question from the side of the symptoms themselves, as it is clearly in that way that you will approach the investigation of an individual case.

First let us consider how the group of symptoms which together make up the condition jaundice will vary when produced by gall-stones, cirrhosis, or cancer.

Obstruction by gall-stones is complete and intermittent.

Obstruction by cirrhosis is incomplete and constant.

Obstruction by cancer is complete and constant.

One can never hope to make such absolute statements in medicine without exceptions. For instance, a gall-stone may become permanently impacted in the common duct and intermittence give way to permanence, or a

growth may soften, and a permanent obstruction be temporarily overcome. The development of cancer as the result of the irritation of a gall-stone is familiar to you all, and the much rarer event of the development of a simple stricture of the duct from the same cause must be remembered.

Taking note of these exceptions, we may say that the olive-green jaundice of permanent and complete obstruction and the white motions of complete obstruction may be the result of either cancer or gall-stones, and that the existence of either of these features will generally allow you to safely exclude cirrhosis.

Probably, the next investigation you will make will be into the history of pain. There are two kinds of pain dependent on liver disease, a constant pain caused by distension of the capsule and pressure on neighbouring sensitive structures, and a paroxysmal pain due to vigorous peristalsis of the bile ducts. The former, if it is of any assistance, and it will only be so when it is severe, will point to cancer rather than to either of the other causes; the latter when present will always be suggestive of stone, and will enable you to exclude cirrhosis, but cannot with safety be allowed to put cancer out of the question. Do not forget, however, that any sort of jaundice may be complicated by renal or intestinal colic, and that such an association is fraught with danger for the unwary. The prevalence of surgical interference for the relief of cholelithiasis makes it more than ever important to exercise caution in this matter, especially if you are disposed to rely on the patient's own history, both for the existence of the jaundice and the special character of the pain. On the other hand, there is little doubt that true biliary colic may be produced by the partial obstruction of cancer. It is difficult to prove, because an unobserved stone can always be called in to explain the colic, but analogy with intestinal colic due to cancerous stricture of the colon, for the production of which no one, I believe, thinks a solid mass of fæces necessary, lends much support to the view.

Turn now to the examination of the liver. In all three causes the tendency is to enlargement, for you remember that the cirrhotic liver that is accompanied by much jaundice, is rarely the contracted hob-nailed liver. The liver enlarged by gall-stones, or by cirrhosis, is generally smooth on the surface, while the cancerous liver may often have detectable secondary deposits raised from its capsule. If the enlargement of gall-stones or cirrhosis has been rapid, the liver may be tender, but exquisite sensitiveness generally points to cancer. The cirrhotic liver is generally harder than that which is merely distended by bile, but stony hardness, unequally or equally distributed, is not caused otherwise than by malignant growth.

The condition of the gall-bladder is often of great assistance. Whether it be distended or not depends, of course, mainly on the situation of the obstruction. One would be inclined at once to say that in cirrhosis, where the obstruction is in the biliary radicles, the gall-bladder can never be distended, and it must certainly be a most exceptional case when this rule is broken. One cannot help remembering that in certain ill-understood conditions a gall-bladder may enormously increase in size without any obvious obstruction. Atonic or paralytic distension, the condition has been called, and comparison has been made with paralytic dilatation of the stomach and hydronephrosis. A desire for general accuracy rather than occasional brilliancy in diagnosis would lead us to hold fast to the rule that white motions and a distended gall-bladder cannot be caused by cirrhosis.

The absence of distension of the gall-bladder is of much less service, and both cancer and gall-stone obstruction are frequently present without it. There are two obvious explanations of its absence. First, there may be no gall-bladder. It may be a mere fibrous relic altogether cut off from connection with the biliary passages. This is more likely to be the case where gall-stones are the only cause, or where cancer has been produced by gall-stones.

Secondly, the obstruction to the outflow of bile may be situated on the gland side of the cystic duct. This is more likely to be the case in cancer than in gall-stone, for a stone that can get into the hepatic duct will rarely be arrested till it reaches the biliary papilla. Cancer may not uncommonly originate in the hepatic duct, and in cases of diffused growth it seems that cancer may cause jaundice by pressure on the minute branches of the hepatic duct in the liver, just as is the case in cirrhosis.

But to complete our diagnosis, we must not confine our attention to the immediate effects of the cause upon the liver and the secretion of bile. We must remember that two of our causes may have far-reaching effects upon the patient generally and upon the portal circulation

in particular. These two causes are cirrhosis of the liver, and cancer.

We must remember the ultimate causes of these two causes. We must remember that alcohol, to take the commonest cause of cirrhosis, and the mysterious influence, virus or micro-organism that produces cancer, will both of them almost certainly produce effects other than those local ones in the liver which have brought the case to our notice to-day.

Look for the other effects of drink upon your patient's mind and nervous system, but do not forget that a drunkard may have gall-stones and cancer. Remember that cancer of the liver is commonly secondary, and give weight to indications that there is cancer elsewhere—in the alimentary canal, or the breast.

Turn once again to the liver and we have finished. The inert gall-stone does little beyond causing its obstruction. It may pass on and trouble our patient no more; it may rest impacted until one day a local abscess, a sudden acute peritonitis, or an attack of intestinal obstruction indicate that it is ulcerating its way out.

Cirrhosis and cancer are much more progressive, and indications of the gradual destruction of the substance of the liver, may soon become evident. Moreover, in both these conditions, an entirely new group of symptoms, accidental it is true, but so common as to justify us in looking upon them as an almost essential feature, will in a large number of cases become evident before the patient's death.

A cancerous mass which involves the bile ducts is likely, sooner or later, to compress the trunk of the portal vein, just as the fibrous overgrowth in the cirrhotic liver which obstructs the biliary radicles, will ultimately tend to interfere with the circulation in the portal capillaries.

The presence in a patient with jaundice, of signs of portal obstruction, such as enlargement of the spleen, ascites and hæmorrhoids, should lead us to exclude gall-stones, but will leave it an open question as to whether cancer or cirrhosis is the cause.

Thus I have presented to you what may be called the alphabet of the diagnosis of jaundice. Until one is familiar with the methods of distinguishing between these three common causes, it is impossible to venture safely into the obscurities of acute yellow atrophy, pylephlebitis and aneurysms of the hepatic artery.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY	4.	Mitral regurgitation. ? Aortic stenosis.
	23, 37.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	24.	Aortic aneurysm.
	33.	Mitral regurgitation.
	48.	Mitral regurgitation.
	55.	Bronchitis.
PHILIP	23, 30, 32.	Aortic stenosis and regurgitation.
	35.	Mitral stenosis and regurgitation.
STEPHEN	14.	Mitral stenosis.
	21.	Aortic stenosis. Mitral regurgitation.
	27.	Aortic and mitral stenosis and regurgitation.
	28.	Mitral regurgitation.

Nervous System.

MARY	9.	Cerebral tumour. Optic atrophy. Trephining.
	12.	Sciatica.
	14.	Paraplegia. ? Hysteria.
	22.	? Chronic meningitis. Thrombosis of sinuses. ? Abscess.
	40.	Chorea.
	41.	Paraplegia. Hysteria.
PHILIP	31.	Peripheral neuritis. Wasting of muscle.
STEPHEN	2.	Peripheral neuritis. Syphilis.
	4.	Locomotor ataxy. Charcot's joints.
	5.	Ataxic paraplegia.
	24.	Locomotor ataxy.
	25.	Right hemiplegia.
	32.	Cerebral syphilis.

Alimentary System and Abdomen.

MARY	5.	Carcinoma of pylorus. Dilated stomach.
	7, 10, 16.	Gastric ulcer.
	45.	Epithelioma of œsophagus.
	50.	Abdominal pain and distension. Diarrhœa. ? Cause.
	51.	Tuberculous peritonitis. Fæcal fistula.
	54.	Ascites. ? Tuberculous peritonitis.
PHILIP	2, 9, 14.	Carcinoma of stomach.
	13.	Jaundice. Enlarged liver.
	15.	Abdominal cyst. Operation. Drainage.
	36.	Enlarged liver.
	37.	Tuberculous peritonitis.
STEPHEN	11.	Carcinoma of stomach.
	13.	? Lead poisoning.

Typhoid Fever.

MARY	2, 17, 18, 27, 29, 43, 47, 49, 55.
PHILIP	1, 4, 5, 24, 28.
STEPHEN	7, 17, 18, 35, 37.

Genito-Urinary System.

MARY	6.	Tuberculous kidney.
	20.	? Renal calculus.
PHILIP	17, 40.	Chronic interstitial nephritis.
	18, 20.	Chronic tubal nephritis.
	31.	Chronic interstitial nephritis.

Respiratory System.

MARY	11.	Tuberculous pleurisy. Phthisis.
	32.	Pleurisy. Rickets.
	34, 39.	Phthisis.
	38.	Empyema.
PHILIP	10, 11, 39.	Phthisis.
	16.	Bronchitis.
	19.	Pleurisy. Fœtid expectoration.
	26.	Double empyema.
	29.	Empyema.
	34.	Pneumonia.
STEPHEN	1.	Pleuritic effusion.
	3.	Empyema.
	6.	Acute laryngitis. Tracheotomy.
	10.	Pleurisy. Broncho-pneumonia.
	23.	Phthisis.

Miscellaneous.

MARY	1.	Gout.
	3.	Pyrexia. ? Cause.
	25, 31.	Rheumatism.
	28.	Congenital syphilis.
	30.	Addison's disease.
PHILIP	3, 27.	Rheumatism.
	22.	Eczema.
	33, 36.	Tertiary syphilis.

CASE UNDER DR. GOODHART.

ABDOMINAL CYST.

PHILIP.

15. G. B., æt. 49, a male. Admitted on June 5th for a tumour in the abdomen. He has always been a strong healthy man—a coachman by occupation—and has never been out of England. For the last six months he has noticed that his abdomen has been increasing in size, but as it never caused him any inconvenience he regarded it merely as increasing obesity. On May 23rd, however, he had a severe attack of shooting pains, which commenced when driving over a stony road, and were worse on movement, but speedily disappeared on his remaining in bed for a few days. He has never had any gastric or urinary trouble.

On admission.—He was found to have a large globular tumour in his abdomen, occupying the lower more than the upper part. It is situate almost in the middle line, but is perhaps most prominent just by the right of and below the umbilicus. The umbilicus itself is slightly flattened, and is considerably nearer the ensiform cartilage than the pubes. The tumour is felt to be very tense, and there is a well-marked thrill. The outline can be made out all round the upper and lateral margins but is lost in the pelvis below. On either side, situated low down in the flanks, can be felt a small tumour, which is much softer than the large median one, but attached to it. These lateral swellings are oval in shape with their long axes running vertically downwards. During a deep inspiration the edge of the liver can be felt coming down over the upper margin of the tumour, which does not move. The spleen cannot be felt. The whole tumour is dull on percussion, but there is an area of resonance above it, between it and the costal margin, and the flanks also are resonant. The heart is displaced upwards, the dulness commencing at the third rib, and the impulse being in the fourth space. Stomach resonance goes up to the fifth rib, and liver-dulness to the sixth rib, in the nipple line. By means of a catheter it is found that the bladder is behind the tumour. The urine is normal.

Diagnosis before the operation.—Hydatid cyst, probably of the peritoneum. Cyst of the pancreas and hydatid of the liver were also discussed, and excluded. If the patient had been a woman, ovarian tumour would probably have been diagnosed.

On June 7th patient was operated on by Mr. Lane.

A median incision about four inches long was made between the umbilicus and the pubes, and the wall of the cyst was exposed. This was now aspirated and freely opened. On exploring the cyst, no communication with any organ could be made out, it was adherent in the right iliac fossa, and had the vermiform appendix attached to it. The walls were thick and fibrous. A large glass tube was fastened into the cyst and the wound sutured and dressed. There was a slight discharge from the tube for the first two days, since then nothing has come away. Patient is quite comfortable, and has had no rise of temperature. The fluid drawn off from the cyst measured ʒ95. It was of a greenish-yellow colour. Sp. gr. 10·12, and contained a large quantity of albumin and a trace of urea. No scolices or hydatid hooklets. The origin of the cyst is not obvious; it was, however, probably retroperitoneal, and not hydatid as was thought before the operation.

CASE UNDER DR. HALE WHITE.

STEPHEN.

36. B. H., æt. 50. Admitted May 8th, 1895, for pain in left chest and dyspnœa. No family history of consumption. Patient had pleurisy five years ago on the left side. About Christmas patient noticed pain in left chest and shortness of breath on exertion. He was seen by the parish doctor, who sent him to a convalescent home. He got much worse, and was sent up direct to Guy's Hospital. Patient has no appetite. He has a slight cough with expectoration of nummular mucopurulent sputum. He has lost flesh rapidly of late. No hæmoptysis or hæmatemesis. He is not sick in the mornings and does not sweat at night. Patient is a moderate drinker, sometimes taking spirits.

Condition on admission.—Temperature 95·2°. Pulse 94. Respiration 28. Patient is very emaciated and anæmic. He has clubbed fingers.

Respiratory system.—No dyspnœa. Very slight cough. Chest is very thin. The right side only is used in respiration, the left side being drawn across to the right during inspiration. Great sucking in of lower spaces on left side. The epigastric angle is not symmetrical, the right side being wide while the left side is narrow. T.V.F. is normal all over chest. The left chest is dull in front down to the fifth rib, there being no difference between the lung and cardiac dulness. Left axilla is dull down to the level of nipple. Behind there is absolute dulness down to the spine of the scapula, and partial dulness to the angle of scapula. The right chest is normally resonant. Consonating râles are heard all over left chest in front. Over an area limited above by the second rib, and below by the fifth rib, and reaching from the left border of the sternum to two inches outside the left nipple, tubular breathing, pectoriloquy and bronchophony are to be heard. The breathing of the right chest is normal. At left apex behind there are consonating râles, bronchophony and pectoriloquy.

Circulatory system.—Normal.

Alimentary system.—Abdomen looks fuller in the right hypochondriac region. On palpating the abdomen the liver is felt. The well-defined hard smooth edge is easily felt on the level of the umbilicus. The edge is four inches below ribs in the right nipple line. The surface of the liver is smooth and hard. The spleen cannot be felt.

Liver dulness commences at sixth rib.

Tubercle bacilli were found in sputum. A few consonating râles were heard in right axilla a week after admission.

Diagnosis.—Phthisis of left lung and cirrhosis of liver. A fortnight after admission the spleen was found to be enlarging, and Dr. Hale White diagnosed lardaceous disease; in addition patient complained of hoarseness in his throat.

On June 5th patient was suddenly taken with dyspnœa and pain in the throat. He got steadily worse and died quietly on June 8th, at midnight.

Autopsy.—Small traction pouch in œsophagus opposite bifurcation of trachea. No affection of larynx.

Lungs.—*Left lung* solid and covered with thickened pleura, firmly adherent to chest wall. Small patch of healthy lung at base. A good deal of interstitial thickening of the rest of lung, with caseating patches. *Right lung.*—Innumerable tubercles. Acute pneumonic process.

Liver.—88 ounces. Cirrhotic and lardaceous change.

Spleen.—7 ounces. Some lardaceous change.

Kidney.—Unaffected.

Intestine.—Circular tubercular ulceration in large intestine. Commencing lardaceous disease in large and small intestines.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN	6.	Suppuration in shoulder-joint. ? Scarlatina.
	11.	Ruptured urethra. Perineal abscess. Incision.
	12.	Ruptured urethra. Extravasation of urine. Gangrenous scrotum. Incisions.
	13.	Loose cartilages in knee-joint. Removal. Old injury.
	19.	? Suppurating gumma on buttock.
CHARITY	11.	Scirrhus mammæ.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS	5.	Arm torn off just above lower epiphysis of humerus. Amputation.
	6, 18.	Compound fractures tibia and fibula.
	17.	Fractured olecranon; fractured twice formerly; fragments wired.
LYDIA	5.	Concussion. Paresis of left arm.
	8.	Large patch of lupus on buttock. Tuberculus ulceration on face.
	18, 21.	Carcinoma mammæ.
LUKE	6.	Rodent ulcer. Excision.
	15.	Epithelioma of lower lip. Excision. Plastic operation.
	20.	Strangulated femoral hernia.

CASES UNDER MR. LUCAS.

ACCIDENT	24.	Concussion. Bleeding from nose and ear. ? Fractured base.
LYDIA	11.	Tumour of breast. ? Carcinoma.
	16.	Chronic abscess over inner side of elbow-joint. Movements of joint not limited.
JOB	1.	Genu valgum. Distance between inner malleoli when legs extended thirteen inches.
	8.	Loose semilunar cartilage. Previously stitched. Removal.
	22.	Epithelioma of palate, etc. Excision with part of upper jaw.
	23.	Carcinoma of male breast. Excision.
CHARITY	2.	Depression of skull dating from birth. Hemiplegia. Aphasia.
	22.	Tonsilitis. Adenitis. Nephritis.
	Cot.	Contraction of anus following scald on buttock.

CASES UNDER MR. GOLDING-BIRD.

MARTHA	3.	Intercostal paralysis. ? Peripheral neuritis.
	5.	Pes cavus.
	16.	Spinal caries. Paraplegia.
	17.	Congenital torticollis. Left-sided.
	Cot.	Hypospadias.

LAZARUS 4. Genu valgum.
7, 17. Irreducible inguinal hernia.
8. Hydrocele tunica vaginalis.
11. Ulceration of palate. ? Tuberculous.
14. Stricture of urethra. Retention. ? Ascending nephritis.

A Case for Diagnosis.

FROM NOTES BY MR. C. G. BURTON.

John J., æt. 48. Admitted May 7th, at 10 p.m., with "aphasia" and paralysis of tongue and thorax. History of a fall a fortnight ago, but patient quite recovered. He was at work on the day of admission and quite well. Has been a heavy drinker, but not lately. Denies history of syphilis.

On admission.—Patient was collapsed. Pulse weak and slow; respiration entirely diaphragmatic. Patient could not speak or swallow. There was marked paresis of arms and legs. No paralysis of facial muscles. Patient could not speak or put out his tongue or swallow. He was quite sensible. Sensation quite normal all over body. Pupils normal; no strabismus. Chest full of mucous râles. Patient appeared to be dying and his friends were sent for.

May 8th. Patient was much better this morning. There was no paralysis of limbs, but marked paresis, especially of right side. Respiration quiet and thoracic. Patient could not talk or put out his tongue. Patient got worse at night. Pulse weak, and respiration more difficult. Improved under brandy. Cardiac system normal.

9th Patient better to-day; limbs still slightly paretic; tongue very thickly coated; knee-jerks absent. Plantar reflex present. Patient can swallow quite easily. Patient complains of headache and of an area of tenderness on tapping side of head in left temporal region. Optic discs normal.

14th. Slight paresis of hands still remains, especially the right. Patient can speak fairly well. Gets up on a chair.

26th. Improvement continued. Still weak in arms and legs. Speech still thick. Can put his tongue right out. Right knee-jerk present; left absent.

June 8th. Slow, but steady, improvement. Gets up every day. Can walk a little. Speech clearing.

15th. Went out well, except for slight impairment of speech.

S. G. FLOYD.

Swansea.

Appointments.

HARRIS, JOHN WM., M.R.C.S., L.R.C.P. Lond., has been re-appointed Medical Officer for the Frittenden District of the Cranbrook Union.

WEBBER, H. W., M.D., M.S., has been appointed a Divisional Surgeon to the Herts County Police.

From the Gazette's Special Pathologist.

ALL specimens — particularly those of solid tissues — should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be dispatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

H. L., SALFORD.—On section, the tumour is chiefly composed of large mucous glands. The duct of one of these is distinctly dilated. The mucous membrane shows a low warty growth, probably the result of the irritation; but there is no indication of malignant disease.

A. D., WANTAGE.—The growth is a typical scirrhus carcinoma of the breast. The fibrous stroma is exceptionally abundant.

C. P., BARTON-UNDER-NEEDWOOD.—Tubercle bacilli are present in fairly large numbers.

W. S. H., CROMWELL ROAD.—The section of gland shows several small nodular deposits of tubercle. They are undergoing degenerative changes.

G. S. S., NORTHFLEET.—After twenty-four hours' cultivation upon blood-serum, several rounded whitish colonies had made their appearance, which, on microscopical examination, proved to be composed of typical Klebs-Löffler bacilli in an almost pure cultivation.

G. Z. H., BALHAM.—No tubercle bacilli could be found in the sputum.

H. W., NOTTINGHAM.—The fluid has the characters of peritoneal effusion. It is neutral; sp. gr. 1004; contains much albumin and a good number of pus-cells. Taken with the clinical history, these features indicate some peritoneal irritation, possibly the remnant of the blood cyst not removed. The fluid does not come from the bladder and probably not from an ovarian cyst.

S. R. H. M., BICKLEY.—This specimen, besides the ordinary débris, contains a larger quantity of epithelial cells than is usual in specimens of the kind, suggesting a catarrhal condition of the intestine. No bacteriological examination has been attempted.

PATHOLOGIST.

Guy's Hospital Christian Union.

ON Tuesday evening, June 18th, the Treasurer presided over a Missionary meeting in the Court Room, the object of which was to unite the whole of the missionary interests in the Hospital. There were present, besides the Chairman, Mrs. and Miss Davies-Colley, the Matron, Miss Macleod, Sisters Philip, Ruth, Out-patients, Cornelius, Charity, Accident and Luke, and about 50 lady pupils and nurses; the Chaplain, Mr. Targett, the Librarian, several visitors and about 40 students, bringing the total up to over a hundred and twenty. Dr. Goodhart and Mr. Davies-Colley had hoped to be present, but were prevented at the last moment.

After the meeting had been opened with singing and with prayer offered by the Chaplain, the Missionary secretary, Mr. A. W. Ormond, gave a short account of the objects and work of these meetings, the first of which was so successfully held last March. Instancing the success of the Clubs' Union as an example of the benefits of combination, he pointed out the advantage of gatherings which would combine and maintain the deep interest in foreign medical mission work felt by both nurses and students, and expressed great pleasure at the presence of the Treasurer and the Matron.

The Rev. H. G. DANIELL BAINBRIDGE, chairman of the S. P. G. Junior Missionary Association, pointed out that the clergyman and doctor were eminently fitted to work together and to fulfil the Saviour's dual command to preach the gospel and heal the sick. He referred to the prevailing ignorance of the nature and extent of missionary work, and said, that in view of the enormous needs of the heathen world, all self-interest should be sunk and all differences forgotten in order to further this work.

Tea and coffee were now served in the board-room, after which—

The TREASURER, resuming the chair, said that the secretary and Mr. Bainbridge had spoken of the need for combination, and it seemed to him that there was no place where such a spirit of unity would be better appreciated than here, where all were filled with one desire for the benefit of the patients and the well-being and high character of this Hospital. He remembered the great influence which was wielded many years ago by Bishop Cotton, of Calcutta. Respected alike by Presbyterians, Nonconformists, and High, Broad, and Low Church, he preached unselfishness and charity until he met with his untimely and sudden death. Missionaries were often not able to see the fruit of their labours, as in a case which came under his own notice of a woman who, surrounded by Brahmin relations, derived comfort and blessing during many years from a Bible hidden in her room; not until the end of her life was she able to tell her brother, himself a Christian in the employ of Mr. Lushington, of this precious possession. On one occasion, after the mutinies, he entered a town last occupied by the rebels and was surprised to find the church still standing with only one shot-hole through the spire: upon enquiry he found it was left because of the respect and affection which the missionaries had inspired among the natives. This was only one example of the kind of feeling towards the missionaries which prevailed in India. He had known people come 15 and 20 miles to church, even though they had to make a fire to boil their rice and sleep in the churchyard. The Zenana work was most useful and important, from all points of view; the visitor, by instructing a Hindoo woman in the rudiments of general knowledge, enabled her to help her husband in his affairs—such as accounts, which often baffled him—and thus the man began to respect his wife and treat her on a different footing. It is first necessary to sweep away the jugglery which pervades all Hindoo life, and then to plant the good seed, which, by the blessing of God, is growing and will grow.

The Treasurer then invited the nurses willing to become members of the Guy's Missionary Society to write their names on the backs of the slips of paper distributed, on which were printed the objects and rules of the Society.

The Rev. H. SYKES, of Palestine, gave an account of the work in Palestine, mentioning Jaffa as the chief missionary centre, with a hospital carried on by a native medical man with English lady workers. At Jerusalem there are so many doctors of various nationalities that a medical mission is hardly needed. At Salt there is a hospital with a yearly attendance of 7000 out-patients. A good work was commenced at Kerak by Mr. Letherby for the Wesleyan Missionary Society; it has been lately taken over by the Church Missionary Society, and is greatly in need of a medical man. Purely religious work, in fact, in Palestine is always difficult and often impossible, while medical skill at once opens the door for the missionary. An itinerant doctor and priest is also very much needed. Quoting our Guy's motto, "Dare quam accipere," the speaker asked for the prayers and interest of his audience for the Kerak work.

Canon SCARTH, of the St. Andrew's Waterside Mission, unfortunately had to leave earlier than was expected, and, to the great disappointment of the meeting, did not speak. He has, however, kindly promised to visit us on a future occasion.

Pass List.

University of Cambridge, June, 1895.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART II. (HUMAN ANATOMY AND PHYSIOLOGY).

Allan, H. W. Denyer, S. E.
Lindsay, W. J.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The "United Guyite Club."

DEAR MR. EDITOR,—It may be interesting to the readers of your GAZETTE to know that what is now the oldest Students' Club—the "United Guyite Club"—held its forty-fifth anniversary on Thursday, June 13th, at the Criterion Restaurant, and that nine out of the twelve existing members of the Club dined together; the original number of members having been twenty-eight. The chairman on the occasion was Frederic Duke, of Buckingham, and the vice-chairman was the secretary—Thomas Bryant. The other members present were James Bisshopp of Tunbridge Wells, W. A. Skinner of Hastings, E. Marshall of Mitcham, Robert Stevens (Bob) of Hoddesdon, F. Martin of Beckenham, J. S. Stocker of Montagu Square, and William Hills of Thorpe St. Andrew, Norwich, the son of old Hills, known and highly valued by old Guy's men as "Governor Hills," or the "Governor."

The "old boys" had a very pleasant meeting, and the chairman, in words which came from the heart and which found an echo in the hearts of all present, dwelt upon the great value which the Club had been to its members, and how it had more than realised the objects for which it was founded.

Indeed, Mr. Editor, the suggestion that a notice of its meeting, with this conclusion arrived at after forty-five years' experience, should be sent to you, came from the members of the Club, with the object of encouraging the formation of similar Clubs by the rising generation of Guy's men, and I, as hon. secretary to the Club since its formation, and as a member who has never missed one of its meetings, do this with pleasure.—Yours very sincerely,

THOMAS BRYANT.

65, Grosvenor Street, W.

Past v. Present Cricket Match.

DEAR SIR,—I am writing this letter with the view of obtaining the opinion of both old and present Guy's men as to whether it would not be advisable to fix a certain date in the year for the Past v. Present cricket match.

Now that we have such a splendid ground so close at hand, we ought to have a regular Guy's day there, and the summer is, of course, the best time for it. The difficulty that at present exists in getting up a thoroughly representative team of old Guy's men is, I feel sure, that a great many of those who would be very anxious to play cannot do so on account of the comparatively short notice and the alteration of date each year.

If, however, the day were absolutely fixed, it would very soon become a red letter day in the calendar of Guy's men both past and present; all would know when it was to take place, and not only would there be no difficulty in getting up one team, but we should be able easily to get up two elevens if the ground would accommodate us. If, however, we could not get up two cricket matches, a tennis as well as a cricket match might be arranged. It would also soon become a meeting day of all old Guy's men even after they had passed the stage of playing cricket, etc., just as much as the "Biennial" is now.

We found at school exactly the same thing as I have described above. Now that for the last twelve years the day has been fixed, we have not the slightest difficulty in getting three teams together, and could easily get more if the ground would allow of it; and the day is regarded as a general holiday for both past and present boys and the day of meeting of old boys in the year.

The day that struck me was Whit Monday, more because it was a day with a name, and therefore more definite than, for example, fixing the match for the last Saturday in May. In addition to the matches on the ground, we might, of course, have a dinner in the College together afterwards.

However, such details would, of course, be fixed by the Clubs' Union Committee, I presume; and all I am anxious to see is the date fixed.—I remain, Sir, yours sincerely,

J. FAWCETT.

The College, Guy's Hospital.

The Conjoint Board Examiners.

THE following are the Examiners appointed to conduct the several Examinations under the Conjoint Board:—

FIRST CONJOINT.

Elementary Anatomy.—Hutchinson, J., jun.; Jessop, Walter H. H.; *Roughton, Edmund W.;* Waterhouse, Herbert F.

Elementary Physiology.—Bradford, John Rose.

Elementary Biology.—Buckmaster, Geo. A.; Dean, Henry Percy.

SECOND CONJOINT.

Anatomy.—Lucas, Richard Clement; Makins, George Henry; Walsham, William Johnson; Young, Alfred Harry.

Physiology.—Halliburton, William Dobinson; Power, D'Arcy; Spencer, Walter George.

FIRST FELLOWSHIP.

Anatomy.—Haslam, William Frederick; Jacobson, Walter H. A.; Lockwood, Charles Barrett; *Sutton, John Bland.*

Physiology.—Lowne, Benjamin Thompson; *Schäfer, Edward Albert; Starling, Ernest Henry;* Stirling, William.

MIDWIFERY.

Duncan, William; Handfield-Jones, Montagu; Herman, George Ernest; Routh, Amand.

PUBLIC HEALTH.

Part I.—Turner, George.

Part II.—Seaton, Edward.

Those whose names appear in italics are the new Examiners.

Passim.

THE first list of subscriptions to the Arthur Durham Memorial, which is published in another column. will be perused with much interest. It will be noticed that within ten days from the project being started, nearly one-third of the whole sum required has been received or promised. But it must be remembered that the first list is always the easiest to obtain, and we earnestly ask all our readers who have not already sent in their donations to do so at once, in order that another list, larger if possible in amount, may appear in our next issue. We shall also hope to see the contributions of present students included in the second list. The Collecting Commmittee are wisely desirous of moving as swiftly and systematically as possible.

THE annual contest for the Inter-Hospital Athletic Championship proved to be one of the greatest merit, and it was disappointing that such a small company assembled to witness a struggle, the like of which it has seldom been our lot to see, and the memory of which will last for many a day. The Guy's representatives performed splendidly, and they are to be greatly complimented on the form which won once again for their Hospital the much coveted Shield.

WE are indebted to Mr. S. W. Cock for the clever sketches illustrative of the proceedings at the recent meeting of the Athletic Club. It is yet early days for Mr. Cock to have caught the peculiarities of the men of his generation at Guy's, so we may expect greater things from him before his course here is over.

MR. F. J. STEWARD, whose successes it has been our pleasure to note on several occasions, has added further laurels to his name by obtaining the Treasurer's Gold Medals in both Medicine and Surgery. In our next issue it is our intention to publish an account of his brilliant career, together with his portrait, an announcement which, we are sure, will be received with universal satisfaction.

IN addition to this, the next number of the GAZETTE—our "Speech Day" number—will be made further attractive by portraits of other of our distinguished students, and an illustration from the pen of one of London's ablest caricaturists. A few extra numbers—price sixpence each—of this issue will be printed, for which early application must be made to the Hospital Librarian.

OUR best congratulations are also due to Mr. G. E. Richmond, who has been awarded the Sands Cox Scholarship, the examination for which was so close as to necessitate the awarding of two special certificates to the unsuccessful candidates.

THE letter from the Secretary of the "United Guyite Club," which appears in our correspondence column, reminds us of an idea which it has long been our intention to bring to a practical issue. We know of several such clubs of which Mr. Bryant speaks, and we should like to publish an extensive list of them, with the date of foundation, names of members, constitution, and date of meeting, etc. Only lately we heard of the establishment of several new Guy's fraternities, and an opportunity is now afforded us to collect together a full account of these and others. We are sure that it would greatly interest all Guy's men to know more of their working. We accordingly invite the hearty co-operation of the Secretaries to send us a short account of their respective Clubs with this end in view.

THE Annual Dinner of the Debating Society will take place in the Reading Room on Thursday next, when Dr. Washbourn has kindly consented to take the chair. This event is usually such an enjoyable affair that we hope a large number will be present on the occasion.

As announced in our last issue, Speech Day will be held on Wednesday, July 3rd.

THE Missionary Meeting, held under the auspices of the Christian Union on Tuesday last, was very successful. We hear that an exceptional post is going for a Medical Missionary, the details of which the secretaries of the Union will be pleased to give to any qualified Guy's man anxious to do any work in the mission field.

IN the Inter-Hospital Lawn Tennis Competition the Guy's team were completely outclassed by St. Thomas's, the holders. It is somewhat astonishing to note the complete failure of our players, when it is considered what great advantages the first rate courts at Honor Oak

lend to the production of good form, and more—much more—might have been expected from the hard wear to which the courts have been put this season.

THE Rifle Association has this year been doing great things, having, we understand, won all its matches. This looks well for the Cup ties, and in the meanwhile we are asked to draw special attention to the competition for the Challenge Cup, kindly presented to our Club by Dr. Newton Pitt, announced to take place on Friday, July 2nd.

EVERYONE will be glad to hear that Mr. Tilbury-Brown is now convalescent from the severe concussion it was his unfortunate lot to receive at the Athletic meeting, and will join us in wishing him as complete and speedy a recovery as possible.

THE Cricket Eleven having displayed anything but good form in the early part of the season, are at length showing signs of improvement. In their more recent matches there has been some good scoring among the members of our XI., and the initial stage of the Cup ties has been safely passed by the victory over Westminster.

THE Past v. Present cricket match this year, which was postponed on account of the death of Mr. Durham, will now take place on Wednesday, June 26th, at Honor Oak Park, and will commence at 11 o'clock. The teams will dine together in College afterwards, when it is hoped that Mr. Brailey will take the chair.

THE Past XI. will be selected from W. J. Scott, J. D. Cruickshank, J. H. Joyce, C. J. Francis, W. G. Mitchell, W. I. Hancock, E. T. Shorland, N. H. Pike, J. H. Busteed, R. B. Stamford, H. B. Rygate, S. G. Layman.

THE Committee of the Modern Language Holiday Courses annnounce that the French courses will take place at Caen, August 8th to 28th next. The whole expense of attending a three weeks' course need not exceed £10. Excursions to the surrounding country will also be undertaken, and should any of our readers be desirous of participating in this trip, further particulars may be obtained from Mr. J. W. Richards, The Grammar School, Stoke Newington, N.

Chapel News.

The offertories for the Rochester Diocesan Society this year amounted to £5 19s. 1d.—about £1 10s. more than usual.

"Hospital Sunday" was duly observed at Guy's, as usual. The morning preacher was the Rev. W. E. Collins, Professor of Ecclesiastical History at King's College, Strand. The sermon in the evening was preached by the Rev. L. S. Staley, of Wanstead. The offertory was £3 0s. 6d.—more than £1 less than last year.

Guy's does not stand alone amongst hospitals in contributing to the Metropolitan Hospital Sunday Fund. Seven others send up offertories, and there used to be more even than that number.

There are three reasons why a Hospital Chapel should contribute to this Fund. *First*—it is not possible to find any solid reason why a wage-earner in a hospital should regard himself or herself in a different relation to the Fund from that of a wage-earner in any other place. *Second*—"Hospital Sunday" is an institution which requires to be advertised, and an offering from such convalescent patients as can attend our Chapel may become both a thank-offering for recent benefits, and a hint where to bestow any future subscription. *Third*—it is incumbent upon *all* Londoners to support the London Hospital system.

Anent our late paragraph asking for offerings of flowers for Chapel decoration, it was said to us, a week or two back, that we had "omitted to say what *kind* of flower was wanted." As it turned out, the speaker was under the impression that there were "church flowers," as there are supposed to be "church mice." We beg most emphatically to say that we will welcome *any* gift of flowers.

Four Confirmation candidates were presented at Christ Church, Penge, on Wednesday last.

The Communion Services for July will be Redhead in *D* and Woodward in *E* flat. The Magnificat and Nunc Dimittis will be Statham in *E* flat.

Prize Examinations.

THE TREASURER'S GOLD MEDALS.

The Treasurer's Gold Medals in Medicine and Surgery have both been awarded to Mr. F. J. Steward, M.B., B.S.

SANDS COX SCHOLARSHIP FOR PHYSIOLOGY.

This Scholarship has been awarded to—

Mr. G. E. Richmond, B.A., B.Sc.
,, H. W. Bruce, Prox. Accessit., Certificate.
,, P. Turner, Certificate.

The Arthur Durham Memorial.

IT is proposed to raise a fund of £2000 to endow in perpetuity two beds in memory of the late Mr. Arthur E. Durham. The following is the first list of subscriptions:—

	£	s.	d.
The Treasurer, Guy's Hospital	10	0	0
Pye-Smith, P. H., Esq., M.D., Brook Street	26	5	0
Taylor, Fredk., Esq., M.D., Wimpole Street	26	5	0
Lucas, R. C., Esq., B.S., Finsbury Square ...	26	5	0
Goodhart, J. F., Esq., M.D., Portland Place	26	5	0
Golding-Bird, C. H., Esq., M.B., Queen Anne St.	26	5	0
Davies-Colley, N., Esq., M.C., Harley Street	26	5	0
Hale White, W., Esq., M.D., Harley Street	26	5	0
Horrocks, P., Esq., M.D., St. Thomas's Street	26	5	0
Pavy, F. W., Esq., M.D., Grosvenor Street...	26	5	0
Galabin, A. L., Esq., M.D., Wimpole Street	26	5	0
Howse, H. G., Esq., M.S., Brook Street ...	26	5	0
Bader, C., Esq., Finsbury Circus	26	5	0
Pitt, G. Newton, Esq., M.D., St. Thomas's Street	10	10	0
Groves, C. E., Esq., F.R.S., Kennington Green	10	10	0
Jacobson, W. H. A., Esq., M.Ch., Gt. Cumberland Place	10	10	0
Perry, E. C., Esq., M.D., Guy's Hospital ...	10	10	0
Shaw, L. E., Esq., M.D., St. Thomas's Street	10	10	0
Lane, W. A., Esq., M.S., St. Thomas's Street	10	10	0
Higgens, C., Esq., F.R.C.S., Brook Street ...	10	10	0
Stevenson, T., Esq., M.D., Brixton	10	10	0
Dunn, L. A., Esq., M.S., Guy's	10	10	0
Symonds, C. J., Esq., M.S., Weymouth Street	10	10	0
Wilks, S., Esq., M.D., Grosvenor Street ...	10	0	0
Uhthoff, J. C., Esq., M.D., Brighton ...	5	5	0
Milligan, R. A., Esq., M.D., Northampton ...	5	5	0
Savage, G. H., Esq., M.D., Henrietta Street	5	5	0
Washbourn, J. H., Esq., M.D., Trinity Square	5	5	0
Betts, Mr. W., Museum, Guy's	5	5	0
Ray, E. Reynolds, Esq., Dulwich	5	5	0
Turner, F. C., Esq., M.D., Finsbury Square	5	5	0
Butt, F. K., Esq., Bayswater	5	5	0
Aikin, C. A., Esq., F.R.C.S., Notting Hill ...	5	5	0
Percival, G. H., Esq., M.B., Northampton ...	5	5	0
Beale, E. Clifford, M.B., Upper Berkeley Street	5	5	0
Galton, J. H., Esq., M.D., Norwood... ...	5	5	0
Dalton, B. N., Esq., M.D., South Norwood	5	5	0
Rand, J., Esq., F.R.C.S., Forest Hill ...	5	0	0
Jalland, F. H., Esq., F.R.C.S., York... ...	5	0	0
Kidd, W., Esq., M.D., Blackheath	5	0	0
Barrs, A. G., Esq., M.D., Leeds	3	3	0
France, J. F., Esq., Westbourne Grove ...	3	3	0
Stephens, Lockhart, Esq., Emsworth ...	3	3	0
Goodall, E. W., Esq., M.D., Homerton ...	3	3	0
Roots, W. H., Esq., Kingston-on-Thames ...	3	3	0
Baldwin, F. B. J., Esq., Rotherham... ...	3	3	0
Bossy, F., Esq., M.B., Redhill	3	3	0
Bryant, Thos., Esq., M.Ch., Grosvenor Street	3	3	0
Thomas, J., Esq., F.R.C.S., Swansea ...	3	3	0
Bright, J. M., Esq., M.D., Forest Hill ...	3	3	0
Tubby, A. H., Esq., M.S., Anerley	2	2	0
Farr, E. A. Esq., Andover	2	2	0
Heddy, W. J., Esq., Redcliffe Gardens ...	2	2	0
Pendlebury, J. P., Esq., Ormskirk	2	2	0
Wright, G. A., Esq., F.R.C.S., Manchester...	2	2	0
Ker, H. A., Esq., F.R.C.S., Balham Hill ...	2	2	0
Alexander, S. R., Esq., M.D., Faversham ...	2	2	0
Pye-Smith, R. J., Esq., F.R.C.S., Sheffield...	2	2	0
Blatherwick, H., Esq., Dulwich	2	2	0
Starling, E. H., Esq., M.D., Clifton Hill ...	2	2	0
Holmsted, T., Esq., Bournemouth	2	2	0
Harris, R., Esq., M.B., Southport	2	2	0
Smith, G. B., Esq., B.S., Guy's	2	2	0
Bird, Tom, Esq., Brook Street	2	2	0
Ryle, R. J., Esq., M.B., High Barnet ...	2	2	0
Shadwell, St. C. B., Esq., M.D., St. Andrews	2	2	0
Reinold, A. W., Esq., F.R.S., Blackheath ...	2	2	0
Cole, R. M., Esq., Gloucester...	2	2	0
Reynolds, W. P., Esq., Stamford Hill ...	2	2	0
Phillips, H. A., Esq., M.D., Gravesend ...	2	2	0
Stamper, J. H., Esq., M.D., Pembroke Dock	2	2	0
Spurgin, H. B., Esq., Northampton	1	1	0
Buchanan, A. G., Esq., Surbiton	1	1	0
Pakes, W. C. C., Esq., Trinity Square ...	1	1	0
Crook, H. E., Esq., M.D., Margate	1	1	0
Webster, F. R., Esq., St. Albans	1	1	0
Harday, G., Esq., Rugby	1	1	0
Brumwell, G. W., Esq., Kendal	1	1	0
Russell, J. W., Esq., M.D., Birmingham ...	1	1	0
Rodman, G. H., Esq., M.D., East Sheen ...	1	1	0
Atkinson, T. R., Esq., Sherborne	1	1	0
Bremner, R. A., Esq., Exeter	1	1	0
Gaitskell, E. F., Esq., Sydenham	1	1	0
Warner, P., Esq., Woodford Green	1	1	0
Fisher, W. H., Esq., M.B., Bournemouth ...	1	1	0
Hinton, H. T., Esq., Heytesbury	1	1	0
Halse-Francis, F., Esq., M.B., Norwood ...	1	1	0
Halse-Francis, Mrs., Norwood	1	1	0
Adeney, E. L., Esq., M.D., Tunbridge Wells	1	1	0
Jones, G. M., Esq., Alton	1	1	0
Roberts, R. J., Esq., M.B., Lowestoft ...	1	1	0
Bligh, W., Esq., M.D., Caterham Valley ...	1	1	0
Lockyer, G. E., Esq., Barnard Castle ...	1	1	0
Jones, W. M., Esq., Wath, Rotherham ...	1	1	0
Lucas, H., Esq., Huntington	1	1	0
Mackern, J., Esq., M.D., Blackheath ...	1	1	0
Gillingham, A., Esq., Chiswick	1	1	0
Du Buisson, E., W., Esq., Hereford... ...	1	1	0
Holman, R. E., Esq., Midhurst	1	1	0
Oldham, M. W., Esq., M.D., Burton ...	1	1	0
Newland-Pedley, F., Esq., F.R.C.S., Devonshire Place	1	1	0
Douglas, W. Y. P., Esq., M.B., Newbury ...	1	1	0
Bennett, H., Esq., Builth	1	1	0

	£	s.	d.
Whitworth, W., Esq., St. Agnes	1	1	0
Johnson, D., Esq., M.D., Tulse Hill ...	1	1	0
Swaby-Smith, C., Esq., Ealing	1	1	0
Connolly, B. B., Esq., M.D., St. Johns ...	1	1	0
Hicks, H., M.D., Hendon	1	1	0
Bowes, J., Esq., Herne Bay	1	1	0
Ince, J. Lieut.-Col. Surgeon, Swanley ...	1	1	0
Thorne, J. M., Esq., Redford	1	1	0
Cheesman, J., Esq., M.D., Buckingham ...	1	1	0
Lumley, F. D., Esq., Surgeon R.N.	1	1	0
Osborn, A. G., Esq., Dover	1	1	0
Evans, J. H. Esq., Liverpool	1	1	0
Parke, C. J., Esq., Brockley	1	1	0
Hubbard, F. H., Esq , Maidstone	1	1	0
Sadler, H. H. G., Esq., Canterbury	1	1	0
Cartwright, E. H., Esq., M.D., West Strand	1	1	0
Muriel, G. J., Esq., Whitehaven	1	1	0
Hunter, F. W., Esq., Lavender Hill... ...	1	1	0
Bovill, F. M., Esq., Bishop's Waltham ...	1	1	0
Lyne, W. H., Esq., Liskeard	0	10	6
Scott, A., Esq., M.D., Bocking	0	2	6
	£653	1	0

The Collecting Committee have asked us to publish the following selection from the many appreciative communications received:—

DEAR SIR,—I am most happy to join in perpetuating the memory of my old and very valued friend, Arthur Durham. Please put my name on the list for twenty-five guineas. The form of Memorial is one that will be also doing good for the Hospital.—Yours faithfully,

F. W. PAVY.

35, Grosvenor Street, Grosvenor Square, W.
June 13th, 1895.

Dr. Barrs presents his compliments and encloses cheque for the "Arthur Durham Memorial Fund," with the affectionate good wishes for the success of the fund, from one of Mr. Durham's old dressers.

22, Park Place, Leeds.

DEAR SIR,—I beg to enclose cheque for five guineas to the "Arthur Durham Memorial." I fully sympathise with the form of the memorial, and think there will not be the least difficulty in raising the amount required for one who was such an exceeding favourite with us all.—Yours very truly, G. H. PERCIVAL, M.B.

66, Abington Street, Northampton.
June 13th, 1895.

DEAR SIR,—I am very much obliged to you for giving me the opportunity of subscribing early to the Memorial Fund of my dear old friend, and the form it takes is, I think, most excellent. I enclose you a cheque for £5 5s.; and should the scheme of Memorial be further developed for the benefit of the Hospital, I shall be very glad to double the amount.—Very truly yours,

Dulwich Village, S.E. E. REYNOLDS RAY.
7th June, 1895.

DEAR SIR,—I enclose a cheque, value three guineas, to the "Arthur Durham Memorial," and regret I cannot make it ten times as much, for those who knew him loved him, for his personal kindness knew no limit; those who worked under him will ever remember him, and feel the loss of a teacher, whom none can surpass, and few equal.—Believe me, faithfully yours,

F. B. JUDGE BALDWIN.

Cawdor House, Rotherham.
June 14th, 1895.

DEAR SIR,—I enclose my mite towards the "Arthur Durham Memorial Fund." My feelings at our loss are not the less acute because of the smallness of my contribution. I wish I could send a much larger sum. As one of his dressers in years gone by, I have personally experienced his kindness of heart and genuine interest in the welfare and success of those students who were brought more immediately in contact with him.—I am, dear Sir, yours truly, WM. WHITWORTH.

St. Agnes, Scorrier, Cornwall.
15th June, 1895.

DEAR SIR,—I enclose cheque for one guinea to the "Arthur Durham Memorial," and am sorry I can't send larger just now. In common with every Guy's man, and indeed all who knew him, I was very fond of him, and should like to see a whole ward opened to his memory, and should almost think that with a little work it might be done.—Yours faithfully,

47, Queen Street, Exeter. R. A. BREMNER.
13th June, 1895.

Sport.

Guy's Hospital Athletic Club.

Noboby could have wished for more suitable weather than that which favoured the Annual Meeting of the Athletic Club on Thursday, June 6th, at the L.A.C. Ground, Stamford Bridge. A good number of men mustered round the ropes, but there is little doubt they were outnumbered by the ladies. Most of the Staff were present, there being but a few absentees. Everything passed off smoothly and without a hitch, save the unfortunate fall of Tilbury Brown, who received rather a severe concussion in the Sack Race. Although there were a large number of entries, a considerable number of competitors failed to run or put in an appearance, except perhaps in the 100 yards and 220 yards. At the termination of the sports, Mrs. Higgens graciously distributed the prizes. Mr. Clement Lucas then proposed a vote of thanks to Mrs. Higgens for her kindness, adding that he considered we could have no more suitable person to distribute the prizes than Mrs. Higgens, she being one of the best and keenest sportswomen in Hants. Mr. Lucas then concluded by hoping that Guy's would

prove victorious at the Inter-Hospital Sports, and would continue to hold what trophies they had gained and regain those they had lost. Cheers for Mrs. Higgens, Mr. Clement Lucas, and F. S. Batchelor (Hon. Sec.), brought a very enjoyable afternoon of sport to an end.

The following are the results :—

100 YARDS HANDICAP.—Heat 1: E. A. Longhurst, 1. Time, 10⅘ sec. Heat 2: H. N. Collier, 1. Time, 10⅗ sec. Heat 3: T. M. Walker, 1. Time, 10⅗ sec. Heat 4: H. V. Bagshawe, 1. Time, 11⅕ sec. Heat 5: W. N. East, w.o. Final Heat: Collier, 1; Walker, 2; Longhurst, 3. Won by rather less than a yard. Time 10⅖ sec.

HALF-MILE HANDICAP.—H. A. Munro, 1; F. S. Batchelor, 2. Won easily by a dozen yards, in 2 min. 9⅗ sec.

THREE MILES BICYCLE HANDICAP.—Milbank-Smith, scratch, 1; H. A. Digby, 100 yards start, 2. Won easily by 600 yards, in 8 min. 50⅘ sec.

120 YARDS HURDLES.—Heat 1: G. Naish, scratch, 1; C. E. Hicks, scratch, 2. Heat 2: H. A. Higgens, owed 5 yards, 1; H. V. Bagshawe, scratch, 2. Final Heat: Naish, 1; Higgens, 2; Bagshawe, 3. Won by 2½ yards, in 20½ sec.

220 YARDS HANDICAP.—Heat 1: R. G. Edey, 1; A. H. Finch, 2. Won by a yard. Heat 2: T. M. Walker, 1; H. N. Collier, 2. Won by 3 yards. Final Heat: H. N. Collier, 1; Walker, 2; Finch, 3. Won by 2½ yards, in 22⅘ sec.

THROWING THE HAMMER.—E. N. Scott, who was unopposed, threw 82 ft. 6 in.

QUARTER-MILE HANDICAP.—J. Moore, 25 yards start, 1; George Edey, 35, 2; E. A. Longhurst, 12, 3. Won by a yard and a half, in 53⅖ sec. Five yards between second and third.

ONE MILE HANDICAP.—C. F. Watson, 220 yards start, 1; H. A. Munro, scratch, 2; P. F. Henry, 150, 3. Munro failed to catch Watson in this race, who won by 30 yards, in 4 min. 31⅕ sec. 20 yards between Munro and Henry.

HIGH JUMP.—H. H. Bignold, 4 ft. 11½ in., 1: H. T. Bell, owed 6 in., 5 ft. 4½ in., 2. Both Bignold and Bell jumped well, but Bell after several attempts failed to beat his opponent.

VETERANS' RACE (600 yards).—N. Instone, 15 yards start, 1; J. J. Biggs, scratch, 2; R. H. Randell, 60, 3. This was one of the best races, and was won by 4 yards in 1 min. 2⅘ sec.

PUTTING THE SHOT.—E. N. Scott, owed 2 ft., 33 ft. 3½ in., 1; R. S. Rowland, scratch, 30 ft. 1 in., 2; C. Doyle, scratch, 29 ft. 3 in., 3.

SACK RACE.—Longhurst, 1. About 10 entered for this, entries being taken on the ground. Tilbury Brown when leading 30 yards from home fell.

880 YARDS OPEN HANDICAP.—E. J. Wilkins, L.A.C., 5 yards start, 1; W. E. Jarret, P.B.A.C., 50, 2; B. Lanford, S.L.H., 32, 3. Ten men ran, Wilkins winning an excellent race by 6 yards in 2 min. 3⅗ sec.

WIDE JUMP.—H. A. Higgens, scratch, 18 ft. 5 in., 1; H. N. Collier, owed 1 ft. 6 in., 18 ft. 6 in., 2.

THREE MILES RACE.—P. F. Henry, 2 min. start, 1; E. J. Crew, 2 min. 10 sec., 2. Munro after a few laps fell out, leaving the race to Henry, who won easily by 50 yards in 17 min. 20⅖ sec.

300 YARDS CONSOLATION RACE.—Finch, 1; Beale Brown, 2. Won easily.

The band of the 3rd V. B. Queen's Own Royal West Kent played a selection of excellent music during the afternoon. C.

United Hospitals' Athletic Club.

TWENTY-NINTH ANNUAL MEETING.

There was a fair company of students and friends at the L.A.C. grounds, Stamford Bridge, on Wednesday last, on the occasion of this annual Inter-Hospital contest. The weather was everything that could be desired, the track being in excellent condition after the rain of the early morning, and fast times were the rule. Amongst those present were the Earl and Countess of Egmont, Mr. Clement Lucas (president), Mr. Howard Marsh, Mr. Owen, Mr. J. H. Morgan, Dr. and Mrs. Pye-Smith, Dr. Hale White, Dr. Savage, Dr. and Mrs. Shaw, Mr. and Mrs. Brailey, Mr. and Mrs. Higgens, Mr. Dunn, Dr. Fawcett, and many others. The meeting proved to be one of the greatest interest, nearly all the events producing very keen competition, and until the last race was terminated the issue of the contest was an open matter—an occurrence of remarkable rarity of late years. The fact that six hospitals participated in premier honours afforded great excitement amongst those lining the ropes, and made the sport of a very high order. From the appended details it will be seen that Guy's regained the Challenge Shield by the narrow margin of half a point over St. Mary's, who were a close second.

Our representatives are to be heartily congratulated on the conspicuous success which met their efforts. First and foremost among them we must place Munro, who has now won the Mile and Three Miles five times in succession, establishing Hospitals' record in each event—a feat unparalleled in the history of Hospital Athletics, and one of which Guy's may indeed be proud. Bell was at his best in the High Jump, and showed splendid form. He was, however, unable to quite land the hundred being beaten on the post, and was unable to repeat his previous year's performance in the Long Jump. Scott, in winning the Hammer event, materially assisted in procuring for us the Shield, and Batchelor ran to good effect in the Quarter-mile. The occasion will long be memorable for the splendid struggle for supremacy, and this makes the victory of Guy's in the highest degree creditable.

The arrangements were carried out with excellent results by the officials, and Messrs. Lowe (captain), James (hon. sec.), and Turner (hon. treas.) looked after the competitors in a manner deserving of the utmost praise. The Judges were: A. F. Voelcker, Esq., M.D.; G. R. Turner, Esq., F.R.C.S.; A. A. Bowlby, Esq., F.R.C.S.; H. M. Fletcher, Esq., M.D. Referee: S. K. Holman, Esq. Clerks of the Course: J. G. Turner, Esq., F.R.C.S.; P. Furnival, Esq., F.R.C.S.; A. N. Wilde, Esq.; G. E. Mould, Esq.; P. G. Mould, Esq.; A. R. McCullagh, Esq.; A. P. Square, Esq. Time-keeper: Nat Perry. Starter: C. L. Lockton, Esq.

DETAILS:—

100 YARDS CHALLENGE CUP (presented by St. Thomas's Hospital, 1882).—Holder, H. T. Bell, Guy's; time, 10⅖ sec. Record, B. B. Connolly, Guy's, 10⅕ sec., 1868. Final Heat: H. C. Woodyatt, University, 1; H. T. Bell, Guy's, 2; R. Murray, St. George's, 3. Also ran: C. E. H. Leggatt, St. Mary's; J. Johnson, St. Bartholomew's. Bell got off to a beautiful start and led well into the first 80 yards, when Woodyatt rapidly drew up and appeared to win somewhat easily by less than a yard. Time, 10⅗ sec.

HALF-MILE CHALLENGE CUP (presented by J. G. Beaney, Esq., M.D., Guy's 1879).—Holder, A. Hay, St. Bartholomew's; time, 2 min. 1⅕ sec. Record, A. Hay, St. Bartholomew's, 2 min. 1⅕ sec., 1894. A. G. Butler, St. Mary's, 1; F. F. Elwes, Middlesex, 2. The following did not finish: A. Hay, St. Bartholomew's; H. E. Finch, London; F. R. Barwell, University; H. H. Bignold, and E. A. Longhurst, Guy's; J. Cunningham, St. Thomas's. Bignold led off to a good start and made the pace hot, he was, however, soon passed by Hay, who led over the first lap when he was passed by Butler, followed by Elwes. The pace was very good and the Mary's man made a new record for the Hospitals' Sports, and won by 15 yards. Time, 2 min. ⅖ sec.

PUTTING THE SHOT.—Holder, W. F. Bennett, St. Bartholomew's, 34 ft. 5 in. Record, W. G. West, St. Bartholomew's, 31 ft. 3 in., 1889. W. F. Bennett, St. Bartholomew's, 35 ft. 10 in., 1; E. N. Scott, Guy's, 33 ft. 11 in., 2; H. Webb-Ware, London, 34 ft. 2½ in., 3; A. L. Jackson, St. Mary's, 0; M. Breton, St. George's, 0; C. B. Adams, Middlesex, 0; W. H. Kenrick, London, 0.

120 YARDS HURDLE RACE CHALLENGE CUP (presented by St. Bartholomew's Hospital, 1895).—Holder and record, J. Johnson, St. Bartholomew's; time, 16⅖ secs. Final Heat: J. Johnson, St. Bartholomew's, †; H. N. Coltart, St. George's, †; E. W. Woodbridge, St. Bartholomew's, 3. Johnson got a bad start, and Coltart coming away in grand style, led until the last hurdle, when the former drew level, and the result was

declared a deat heat, amidst great excitement. Time, 16⅗ sec. Every excuse must be made for Lowe, who was beaten in his heat on Monday night, as he was far from well.

220 YARDS CHALLENGE CUP (presented by R. Clement Lucas, Esq., M.B., B.S., F.R.C.S., 1895).—Holder, C. V. Cornish, St. Bartholomew's; time, 23¼ sec. Record, H. T. Bell, Guy's, 22⅗ sec., 1892. H. C. Woodyatt, University, 1; C. B. Adams, Middlesex, 2; C. E. H. Leggatt, St. Mary's, 3. Also ran: E. W. Woodbridge, St. Bartholomew's; P. W. James, St. Bartholomew's. A good race, won by a yard and a half; less than a yard separating second and third. Time, 23 sec.

THREE MILE BICYCLE RACE.—J. Burke, St. George's, 1; A. H. Harris, Middlesex, 2; W. G. Noble, A. T. Harvey and J. H. Tripe, London, 0. The more we see of cycling races the more it seems to us that Stamford Bridge is *not* the place for such an event. Burke was the only one who showed anything like judgment, and passing Harris, who led for over two miles, had the race well in hand for the last two laps, and won by 10 yards. Time, 7 min. 59⅕ sec.

HIGH JUMP.—Holder, S. F. Smith, St. Bartholomew's. Height, 5 ft. 5½ in. Record, H. T. Bell, Guy's, 5 ft. 8 in., 1893. H. T. Bell, Guy's, 5 ft. 7½ in., †; C. B. Adams, Middlesex, 5 ft. 7½ in. †; G.W. Stone, St. Bartholomew's, 5 ft. 6 in., 3. Also jumped: S. F. Smith, St. Bartholomew's; P. R. Lowe, Guy's; C. M. Row, University; C. C. Simson, London; F. R. Barwell, University. By far the best form was shown by Bell and Stone, who both jumped very cleanly and prettily. Adams, if a little awkward, performed well enough to tie with Bell. Both failed three times at 5 ft. 8 in.

THROWING THE HAMMER.—Holder, E. N. Scott, Guy's. Distance, 85 ft. 1 in. Record, J. E. Fraser, St. Bartholomew's, 94 ft. 10 in., 1890. E. N. Scott, Guy's, 85 ft. 11 in., 1; W. F. Bennett, St. Bartholomew's, 85 ft. 1 in., 2; W. H. Kenrick, London, 3. This was very well contested, the victory of last year's winner being the signal for a terrific outburst of cheering from the Guy's contingent, as this virtually assured us the championship.

ONE MILE CHALLENGE CUP (presented by Guy's Hospital, 1879).—Holder, H. A. Munro, Guy's; time, 4 min. 36⅗ sec. Record, H. A. Munro, Guy's, 4 min. 34⅕ sec., 1894. H. A. Munro, Guy's, 1; R. C. Leaming, St. Mary's, 2; M. A. Smith, Charing Cross, 3. Also ran: A. Le Vaughan, St. Bartholomew's; A. Watson, Guy's; F. F. Elwes, Middlesex; H. M. Cooper, St. George's. Watson led off, followed by Elwes, but Munro quickly found first position, and completed his first quarter in 61 sec., and the half-mile in 2 min. 9 sec. He completely out-paced the others, making a new Hospitals' record, and winning by about 80 yards; Leaming, a good second. Time, 4 min. 31⅘ sec.

LONG JUMP.—Holder, H. T. Bell, Guy's, 20 ft. 7 in. Record, B. C. Green, St. Bartholomew's, 21 ft. 3 in., 1891. C. E. H. Leggatt, St. Mary's, 20 ft. 11½ in., 1; H. T. Bell, Guy's, 19 ft. 10½ in., 2. Leggatt jumped in rare form, but could not improve his position. Bell made a disappointing show.

440 YARDS CHALLENGE CUP (presented by G. W. Montefiore, Esq., Guy's, 1879).—Holder, C. V. Cornish, St. Bartholomew's; time, 52⅖ sec. Record, T. A. Guinness, King's College, 51⅘ sec., 1880. A. G. Butler, St. Mary's, 1; F. S. Batchelor, Guy's, 2; P. W. James, St. Bartholomew's, 3; A. Hay, St. Bartholomew's, 0; H. E. Finch, London, 0. Hay made the running and kept the lead a third of the distance, and was then overtaken by Butler and Batchelor in quick succession. On coming into the straight, the latter was hard pressed by James, and Butler running in rare style maintained his lead to the finish, winning by about 10 yards; 3 yards separating second and third. Time, 52⅖ sec.

THREE MILE CHALLENGE CUP (presented by Messrs. Mappin & Webb, 1887).—Holder and record, H. A. Munro, Guy's; time, 15 min. 16 sec. H. A. Munro, Guy's, 1; R. C. Leaming, St. Mary's, 2; M. Mundy, St. Bartholomew's, 3; P. F. Henry, Guy's, 0; J. Hawes, St. George's, 0; G. R. Elwin, St. Mary's, 0; C. D. Edwards, Guy's, 0. From start to finish Munro completely out-classed the others, but there was a keen struggle for second place. In the first mile, which was completed by the leader in 5 min. 6 sec., Leaming, Mundy, Henry and Edwards kept well together. The two miles was done in 10 min. 14 sec, and Leaming was 150 yards behind. At two and a half miles Munro was still forging ahead and had passed the last two men, Henry and Elwin, while Mundy was three yards in front of Leaming. In the last lap the latter drew right away from the Bart.'s man, whom he beat by 60 yards, Munro winning by three parts of a lap. Time, 15 min. 29⅖ sec.

1000 YARDS HANDICAP.—E. J. Wilkins, 24 yards, 1; B. Lawford, S.L.H., 52 yards, 2; E. C. Bredin, scratch, 3. A small field faced the starter for this event, in which E. C. Bredin was to attempt to lower the record. This he not only failed to do, but he was also unable to pass both E. J. Wilkins and Lawford, and ran with nothing like the form he has shown, but struggled hard to overhaul the first two in the straight. Wilkins won by one and a half yards, a like number between second and third. Time, 2 min. 15⅗ sec. The scratch man's time was 2 min. 16⅕ sec.

It will be noticed that this year the Club has to thank St. Bartholomew's Hospital for presenting the 120 Yards Hurdle Challenge Cup, and its President for presenting the 220 Yards Challenge Cup, both to remain the absolute property of the Club. During the afternoon the London Victoria Military Band performed a selection of music, and at the conclusion of the sports the prizes were graciously distributed by the Countess of Egmont.

Mr. Clement Lucas proposed a vote of thanks to the Countess of Egmont for her kindness in coming down to distribute the prizes, which was carried with great cheering. The Countess of Egmont having briefly expressed the great pleasure it had given her to be present, the Earl of Egmont also replied, and a most

successful meeting was brought to a close with the National Anthem.

TABLE SHOWING POSITIONS OF HOSPITALS.

	Bartholomew's.	Guy's.	St. Thomas's	King's.	George's.	University.	Mary's.	London.	Middlesex.	Westminster.
100 Yards ...	5	R4	5	7	2	3	2	1	2	—
220 Yards ...	4	R4	3	9	3	3	—	1	2	—
¼-Mile ...	10	4	—	R10	1	2	2	—	—	—
½-Mile ...	13	2	—	5	3	2	R6	—	—	—
1 Mile ...	4	R6	—	4	6	7	1	1	—	—
3 Miles ...	4	R6	2	1	1	3	4	1	—	—
Hurdles	*R7½	5	5	1	*5½	1	1	—	—	—
High Jump	9	*R10½	5	—	1	—	2	—	*½	1
Long Jump	R8	8	5	2	1	1	1	2	—	—
Hammer ...	R8	7	10	—	4	—	1	—	—	—
Shot ...	R7	9	4	—	1	1	4	3	—	—
Total...	78½	68½	39	39	35½	23	20	9	4½	1
No. of times champion Hospital—	9	8	5	3	3	1	—	—	—	—
No. of records—	4	5	—	1	—	—	1	—	—	—

*R denotes record. The half-point is that scored by hospitals in dead heat events.

The scores this year were:—Guy's, 3½ firsts, 4 seconds; St. Mary's, 3 firsts, 2 seconds; University, 2 firsts; St. Bartholomew's, 1½ first, 1 second; Middlesex, ½ first, 2 seconds; St. George's, ½ first.

Cricket.

The following are the results of the 1st XI. Matches, the full score and analysis of which was received too late for insertion:—

May 22nd.—v. Dunstable Grammar School, at Dunstable.
Guy's, 106 and 73 (for 4 wickets). Dunstable, 168.

May 25th.—v. Mitcham, at Mitcham.
Mitcham, 167 and 116 (for 3 wickets). Guy's, 126.

June 1st.—v. Hornsey, at Honor Oak Park.
Hornsey, 214. Guy's, 174.

June 8th.—v. Bickley Park, at Bickley.
Bickley Park, 113 and 145 (for 9 wickets). Guy's, 54.

June 10th.—Cup Tie.—v. Westminster, at Honor Oak Park.
Westminster 66 and 81 (for 9 wickets). Guy's 210.

June 12th.—v. Brentwood, at Brentwood.
Brentwood 41 and 118 (for 5 wickets). Guy's 240.

June 15th.—v. Eastbourne, at Eastbourne.
Guy's 257. Eastbourne 124.

GUY'S 2ND XI. v. ST. BART.'S 2ND XI.

Played at Honor Oak Park. Team:—

BART.'S

A. H. Skey, b Lavers	6
H. Godwin, b Palmer	0
E. F. Rose, c Lavers, b Palmer	0
H. Pickering, b Lavers	13
J. Collyns, b Palmer	36
J. Maturin, c Anderson, b Lavers	6
T. Body, c & b Anderson	14
G. Watson, c Bignold, b Morgan	25
G. Marrack, c Thomas, b Walker	42
H. Boyle, b Palmer	0
H. Baylis, not out	22
Extras	24
Total	188

GUY'S.

N. Lavers, c Baylis, b Rose	3
H. Bignold, b Rose	0
R. Barron, b Skey	2
H. M. Thornely, run out	5
T. Morgan, b Skey	17
H. Durbridge, retired hurt	0
W. G. Palmer, run out	0
C. T. Anderson, b Rose	0
A. E. Cawston, b Maturin	27
W. M. Thomas, not out	11
T. M. Walker, b Rose	10
Extras	10
Total	85

GUY'S 2ND XI. v. UPPER CLAPTON 2ND XI.

Played at Clapton. Team:—

UPPER CLAPTON.

A. James, b Palmer	7
J. Fox, b Palmer	0
H. Homer, c Levick, b Palmer	72
J. LeKell, b Anderson	8
E. R. Wells, c Morgan, b Anderson	46
R. Parnell, b Palmer	6
H. Hobbs, not out	6
A. Clarke, not out	1
Extras	14
Total	160

Mason, Dunlop, and Hilburn to bat.

GUY'S.

T. Morgan, b James	1
C. Anderson, b Homer	18
W. Palmer, b Homer	6
A. E. Cawston, b Homer	10
G. K. Levick, run out	18
DeCoteau, b Parnell	15
W. M. Thomas, b Parnell	6
G. Shorland, b Parnell	5
Chapman, b Parnell	0
Adams (sub.) not out	1
Extras	14
Total	94

GUY'S 2ND XI. v. DULWICH COLLEGE 2ND XI.

Played at Dulwich. Team :—

GUY'S.

De Coteau, b Gilson	16
C. Anderson, run out	12
W. Palmer, c Gilson, b Wright	5
A. E. Cawston, not out	18
G. Shorland, b Gilson	3
T. M. Walker, b Gilson	0
E. A. S. Cawston, b Gilson	0
R. Barron, c Anthony, b Wright	0
W. M. Thomas, b Wright	0
M. H. Thornely, b Gilson	0
V. E. Collins, b Gilson	0
Extras	12
Total	69

DULWICH COLLEGE.

C. B. Hudson, b Palmer	19
F. Knox, c De Coteau, b Palmer	67
P. Anthony, b De Coteau	24
B. Moss-Blundell, c Palmer, b Cawston	1
W. A. Christie, b De Coteau	17
A. Gillingham, b Palmer	31
C. T. Gilson, b Palmer	31
H. M. Fleming, not out	3
A. Atkinson, not out	6
Extras	28
Total	227

Edwards and Wright to bat.

Guy's Hospital Rifle Association.

GUY'S v. WHITGIFT.

This match was shot at Marden Park range on the 27th ult. We were favoured with better weather than has commonly been our lot, and the shooting was, on the whole, good.

Commencing at 200 yards, Guy's made a total of 204, and our opponents 202, thus leaving the scores at 500 yards to practically decide the match. At the completion of the firing at the longer range, Guy's had added another 204 points to the score, while Whitgift had made 186, thus leaving Guy's winners by 20 points. The scores were as follows :—

GUY'S.

	200	500	Agg'te.
A. Pearson	31	32	63
W. B. Secretan ...	24	26	50
G. G. Ellis	28	27	55
B. W. Moss	23	28	51
W. H. Telling	25	20	45
R. H. Ashwin	23	21	44
S. H. Mason	23	20	43
H. Fulham-Turner ...	27	30	57
	204	204	408

WHITGIFT.

	200	500	Agg'te.
D. Brodie	28	31	59
C. M. Simmins ...	21	24	45
R. G. Reed	28	27	55
S. D. Roper	25	22	47
J. L. Hampton ...	28	25	53
B. Brodie	26	15	41
G. C. Hampton ...	22	25	47
E. Hinks	24	17	41
	202	186	388

GUY'S v. ROYAL COLLEGE OF SCIENCE.

This match was shot on May 22nd, at Runemede. Winning the toss, we decided on 10 shots at each range, as we were unable to shoot at three ranges.

At 200 yards scoring was not high, with the exception of Parkinson's excellent 44, and two of their men came very much to grief. Under these circumstances we went back to 500 yards, leading by 36 points, and settled down to enjoy the remainder of the match. Our opponents' shooting here showed a very decided improvement, every man but one making a higher score than at 200. Parkinson again shot excellently, dropping but three points in his 10 rounds. Our men also, on the whole, improved, Fulham-Turner making 46, and the match was concluded in our favour by the respectable number of 40 points. Scores :—

GUY'S.

	200	500	Agg'te.
C. E. Michael	31	32	64
A. Pearson	41	41	82
G. G. Ellis	37	36	73
B. W. Moss	32	34	66
A. H. Bell	35	28	63
H. Fulham-Turner ...	35	46	81
	212	217	429

COLLEGE OF SCIENCE.

	200	500	Agg'te.
B. Marais	11	28	39
J. C. Moulden	19	30	49
H. Théron	36	28	64
R. C. Burmester ...	31	40	71
W. H. Merrett	35	40	75
T. F. Parkinson ...	44	47	91
	176	213	389

GUY'S v. HARROW.

On June 11th the team journeyed to Harrow, feeling, in the absence of several men on whose aid we had counted, rather like a forlorn hope, remembering, as we did, the display made by Harrow against us last year, when Guy's made a record score of the season, and were beaten by no less than 81 points. Fortunately for us, the mighty had to some extent fallen, and thus left some chance for the exaltation of the humble and meek.

At 200 yards the scores were, in many cases, low, and on the completion of firing here, Harrow had made 187 points as compared with Guy's 173. Starting at 500 yards with an adverse balance of 14 points, our shooting showed a slight improvement, while that of our opponents showed a falling off from their 200 yards score. Fulham-Turner spoiled what would otherwise have been a very fine score by unfortunately dropping his third shot, and scoring an "outer"; as it was, his 31 was the highest score made. At this range Guy's made 194 points and Harrow 169, the result being a win for Guy's by 11 points. The scores were as follows:—

GUY'S.

	200	500	Agg'te.
A. Pearson	26	27	53
W. B. Secretan... ...	24	20	44
B. W. Moss	18	20	38
G. G. Ellis	23	29	52
R. H. Ashwin	23	26	49
A. H. Bell	19	25	44
S. H. Mason	18	16	34
H. Fulham-Turner ...	22	31	53
	173	194	367

HARROW.

	200	500	Agg'te.
H. R. Smith	21	20	41
R. C. Hobson	21	20	48
H. B. Thorp	20	9	29
H. F. Rathbone ...	19	19	38
A. C. Hardman-Jones ...	25	25	50
F. H. Bushell	28	22	50
E. J. Harrison	30	25	55
S. Bouverie	23	29	52
	187	169	356

The Competition for the Cup kindly presented by Dr. Newton Pitt, will take place on Tuesday, July 2nd. This being the first occasion of its being shot for, it is hoped that every member of the Guy's Hospital Rifle Association who takes any interest in shooting will turn up and make the Competition as keen as possible. Details as to the conditions will be announced later, and attention is requested to the notice board in the Colonnade.

Guy's Hospital Golf Club.

GUY'S v. UNIVERSITY COLLEGE.

Played at Raynes Park, on Friday, June 7th, by kind permission of the Raynes Park Golf Club. The match resulted in an easy victory for Guy's. Score:—

C. Coventry	0
E. N. Scott	+1
M. Hamblin Smith	—4
P. R. Lowe	+1
F. G. Thomas	+12
C. Shepherd	+11
	22

Calendar of Coming Events.

To-day. — 1st XI. v. Mitcham, at Honor Oak Park.
2nd XI. v.
Guy's Bicycle Club. Run to Ightham. Meet at Lee Green.

June 24th.—1st XI. v. Surrey Club and Ground, at the Oval.

" 26th.—1st XI. v. Past
Guy's Bicycle Club. Run to Keston. Meet at "Greyhound," Dulwich.

" 27th.—Guy's Rifle Association v. Whitgift (return), Woldingham.
Guy's Christian Union. Missionary Meeting. J. H. Targett, Esq., M.S., in the chair. Address by Rev. F. W. Bradley Dunn.
Second Conjoint Examination begins.
Guy's Debating Society. Annual Dinner. J. W. Washbourn, Esq., M.D., in the chair.

" 29th.—1st XI. v. Chelmsford, at Chelmsford.
2nd XI. v. St. Thomas's Hospital II., at Honor Oak Park.
Guy's Rifle Association v. St. Paul's, at Bisley.
Guy's Bicycle Club. Run to Ripley. Meet at Streatham Church.

July 2nd.—Guy's Rifle Association. Competition for Cup presented by G. Newton Pitt, Esq., M.D.

" 3rd.—Speech Day. Distribution of Prizes by Master of Salters' Company. Band of the Royal Engineers will play during the afternoon.
Third Conjoint Examination begins.

Birth.

MANSELL.—On June 7th, at 44, Wellington Square, Hastings, the wife of E. R. Mansell, of a daughter.

Marriage.

CLOWES—WORTS.—On June 12th, at Holy Trinity Church, Colchester, by the Rev. Canon J. R. Nicholl, and the Rev. J. B. Early, Rector of the Parish, W. F. A. Clowes, M.R.C.S., L.R.C.P., of Coggeshall, Essex, son of F. Clowes, Esq., J.P., of Sutton Hall, Norfolk, to Rose, eldest daughter of E. Worts, Esq., J.P., of Colchester.

Deaths.

CARRINGTON.—On June 10th, at the residence of her son, Dr. W. H. Carrington, 143, Lavender Sweep, London, Louisa Maria, widow of the late Mr. F. G. Carrington, of Gloucester, and mother of the late Dr. R. E. Carrington, of Guy's Hospital, aged 80.

WALES.—At Oundle, Northampton, on May 26th, Herbert J. L. Wales, M.R.C.S., L.R.C.P. Lond., L.S.A., eldest son of Brigade-Surgeon J. Wales, of Priestfield, Mowbray Road, Upper Norwood, aged 27.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette.

JULY 6, 1895.

Speech Day.

THE usual awning had been put up on Tuesday, July 2nd, in the eastern quadrangle of the Hospital, with a platform along the side facing the colonnade. In front of this was tastefully placed a dense line of ferns and tall flowers. The admirable band of the Royal Engineers from Chatham played a selection of soft music on the platform from half-past two till three o'clock while the company assembled, the pieces most appreciated being Gounod's "Mirella" overture and the selection from the "Gaiety Girl."

The programme was tastefully and clearly drawn up and executed; and there was no difficulty in distinguishing the recipients of the different medals and prizes. Some of these were most regrettably absent, and all must have been disappointed at losing an opportunity of doing honour to Mr. Steward, who figured so prominently in the prize list, but was less agreeably engaged in undergoing examination.

The tent, however, proved a bad place for sound, and some of the audience at the back must have had considerable difficulty in catching the interesting speeches of the Chairman and Treasurer, and the neatly-turned phrases of the Senior Physician and Surgeon.

After the formal proceedings were ended, the large assembly, numbering upwards of a thousand persons, dispersed to admire the decorations of the wards, to inspect the laboratories, the Chapel, the College and the Museums; to listen to some excellent selections of music performed in the park by the band, or to an organ recital by Mr. Rich, whose performance was most fascinating, and to partake of refreshments in the College, the Dental building and the disused Addison ward.

Great care had been bestowed on the decoration of the wards; and it is with regret that we find ourselves unable to do full justice to the judgment and zeal displayed thereon by the Nursing Staff. We can only mention in a few words the particular features of each.

The further end of ACCIDENT ward was, unfortunately, darkened by the awning outside; but some beautiful groups of white lilies and tuberoses, and of white and yellow Iceland poppies, lighted up the ward most pleasantly.

CORNELIUS ward made a patriotic display of Guy's colours in blue and yellow corn-cockles, with some fine white lilies and red roses.

In LAZARUS, red and yellow poppies made a very harmonious blend of colour; while on one table was a fine plant of guelder-rose; and pelargoniums, marigolds and sweet-peas were distributed in abundance.

The mantelpieces in JOB were adorned by a row of beautiful roses in white vases; the fireplaces were decked out with some tall lilies and sea-holly, while a table of white lilies and marguerites, with dashes of red gladiolus, poppies and geraniums, was most attractive.

MARTHA displayed the Guy's colours in blue and yellow cornflowers, and one window was especially noticeable with a hanging basket of flowers and steps of sweet-peas and ox-eyed daisies. In one Cot a patient, more quaint than beautiful, had been made up for the occasion out of the Martha doll, and made an eloquent and successful appeal for contributions to the Musical Box.

In LYDIA a most successful plan had been adopted of decorating with wild flowers and grasses, yellow and white bed-straw, field scabious, St. John's wort and honeysuckle, relieved by green spikes of oats and barley.

CHARITY was looking very bright with lilies, crimson sweet-peas and red carnations; and DORCAS with tall white gladiolus, lilies, colias, and feathery asparagus.

In LUKE the door opened on a table of syringa, purple iris, and lilium auratum, another table was very prettily decorated in white marguerites, in white vases, on a white cloth; while the sprays of fern and copper beach on the mantel-shelves formed a pleasing and original contrast.

In SAMARITAN and PATIENCE we especially noticed campanulas, heliotrope and mignonette, and in NAAMAN some pretty variegated gladiolus, red carnations, tiger-

lilies, and canary grass, in addition to the universally-prevalent roses, poppies and sweet-peas.

The CLINICAL wards, at all times very attractive, were further decorated with vases of pink and white gladiolus, sweet-peas and lilies, while one fireplace was most artistically hung with marguerites and drapery.

On our way to the Medical wards we were glad to see the patients from the Eye wards in full possession of three windows from which they could hear, and, so far as in them lay, see what was passing.

RUTH and BARNABUS accordingly furnished a strange contrast, with their empty beds and well-decorated mantelpieces and tables, to the Out-patients' Hall, with its seething mass of patients and total absence of other decoration.

In PHILIP much variety was shown in the arrangement of many beautiful groups of flowers, in which the rich tints of the sweet-peas were particulary noticeable; while in MARY not only were the Hospital colours strikingly displayed in the children's gala dresses of crêpon, the bows of the adult patients and the fire-screen, but two tables near the entrance were one of the best instances of floral decoration we had seen, the smilax creeper constituting a pleasing background to the corn-cockles and marguerites in the one instance, and to the pink and lavender shades of sweet-pea in the other.

Finally, in STEPHEN we had a pretty show of roses and sweet-peas, with some very fine tall hydrangeas in the windows.

In all, we must congratulate the Hospital on a most successful day, and thank the clerk of the weather, *alike for the showers of rain which he had sent us the* previous evening, as for the absence of rain and the presence of sunshine during the afternoon itself.

THE DEAN'S REPORT FOR 1894–95.

In submitting the customary Annual Report of the Medical School of Guy's Hospital the Dean is pleased to be able to record a year's work which has been characterised by steady and gradual progress in all Departments of the School. The changes in the arrangements for teaching that were rendered necessary by the extension of the curriculum have, so far as the earlier subjects of study are concerned, been now completed, and the results obtained by our Students at the examinations in these subjects already indicate that these changes have been such as will enable the School to maintain its high reputation for efficient teaching.

The number of Students who have entered during the past twelve months, both for the entire course and for special departments, with the exception of the Preliminary Scientific (London University) Class, shows a slight decrease as compared with the preceding year. A similar diminution has been observed in the Medical Schools generally throughout the kingdom, and is probably an indication of the prevailing opinion that the profession is overcrowded. In this connection it is interesting to note that the results of the efforts made in this School to obtain for qualified Students remunerative occupations on the completion of their Hospital course do not indicate any increasing difficulty in finding such posts, but would tend rather to show that there is as great a need as ever for well-qualified medical practitioners in this country.

Last year the Medical School regretted that by lapse of time Mr. Arthur Durham's connection with the active Staff of the Hospital had ceased, and congratulated him on his promotion to be a Consulting Surgeon. To-day all past and present students of Guy's Hospital join with Mr. Durham's family and numerous friends in deploring the loss that they and the profession have sustained by his untimely death.

Mr. Jacobson, to the regret of his colleagues and pupils, has resigned his Lectureship on Anatomy. The vacancy thus created has been filled by the appointment of Mr. Arbuthnot Lane, and other consequent changes have been the appointment of Mr. Dunn to be the Teacher of Operative Surgery, Mr. Targett to be Demonstrator of Surgical Pathology, and Mr. F. J. Steward to be one of the Demonstrators of Anatomy.

The wider recognition of the importance of Bacteriology as an aid to correct diagnosis and successful treatment has led to a considerable increase in the work of the department devoted to this science. In order to provide for the patients in the wards the advantages which prompt examinations of this character afford, the Governors have sanctioned the appointment of an Assistant Demonstrator of Bacteriology. Mr. W. C. C. Pakes has been elected to this office. This additional *appointment has enabled the School to increase the* practical teaching of this important subject.

The competition for the Medals and Prizes which are distributed to-day has been thoroughly satisfactory, and in some cases has given rise to a keen though friendly rivalry, which cannot fail to have a good influence upon the course of study within the School.

The Sands Cox Scholarship for Physiology, which is awarded triennially, became vacant this year, and has been the subject of a very close competition.

At the Examinations of the Universities and Royal Colleges, our Students have fully maintained the reputation of the Hospital, both as regards the percentage of passes recorded and the number of Honours gained. The percentage of successes at the various Examinations of the Conjoint Board achieved by Students of this Hospital have in some subjects very considerably exceeded, and in all but one subject, proved better than the general average for all Schools.

At the Examination for entrance into the Navy Mr. Gerald Sichel, F.R.C.S., of Guy's Hospital, was placed first among a large number of candidates.

At the Intermediate Examination for the degree of Bachelor of Medicine at the University of London, Mr. V. E. Collins obtained the Gold Medal in Physiology, and thus won for Guy's Hospital this prize for the third successive year. At the final examination, Mr. A. H. Leete was awarded the Gold Medal and Scholarship

in Medicine; and yet a third Gold Medal was brought to Guy's by Mr. Hugh Davies, who was placed first in the examination for the degree of Bachelor of Surgery.

In the Honours examination for the M.B. more places were awarded to Guy's men than to students from any other Medical School, nearly one fourth of the number of honours falling to our lot. Mr. F. J. Steward was the only candidate who obtained First-class Honours in all three subjects of the examination.

Thirteen Guy's men presented themselves for the M.D., and twelve for the B.S. Examination, and in neither case did any one of them fail to satisfy the examiners.

It is now five years since, at the suggestion of our Senior Dental Surgeon, it was determined to provide the Patients and Students of Guy's Hospital with the advantages of a fully-equipped Dental Department such as has hitherto only been found in Special Dental Hospitals. This action on the part of the authorities has been abundantly justified, both as regards the interests of the charity and of medical education. An immensely larger number of poor patients in the neighbourhood have thus been enabled to receive the benefits of conservative treatment, and an important School of Dental Surgery has grown up in close connection with the Medical School.

As a result of the experience gained in the last five years, certain alterations have been made in the appointments of the Medical Staff and in the constitution of the Dental School, with the object of establishing it on a firmer basis. It is satisfactory to be able to report that all the original Members of the Staff retain their connection with the Dental School.

At the last examination for the Diploma in Dental Surgery of the Royal College of Surgeons the proportion of successes gained by our Students was distinctly above the average gained by Students from all Schools.

It is gratifying to note that the example set by Guy's Medical School in increasing the means of healthful exercise for their Students, by acquiring a private recreation ground within easy reach of the Hospital, has been followed by at least two other Medical Schools in London. The Council of the Clubs' Union report that their ground at Honor Oak Park is in daily use by an increasing number of Students. It is not, therefore, surprising that in the department of Sport, Guy's Hospital takes a foremost place. We would congratulate the Cricket Club on obtaining the Challenge Cup for the tenth time since its institution fourteen years ago, the Cross Country Team on securing the Trophy for the fourth year in succession, and the Athletic Club on bringing back the Shield which last year they failed to win by a very narrow margin. The following clubs must also be congratulated on having made a good fight for their respective Challenge Cups in the various contests for which they have only been beaten by the actual holders:—The Rugby and Association Football Clubs, and the Lawn Tennis Club.

In conclusion, the Dean, on behalf of his colleagues, would express the satisfaction that it gives them to welcome as the Distributor of the School Prizes one who personally and through the powerful City Company of which he is the Master, has done so much to assist the Hospital, and in assisting the Hospital, has effectively promoted the cause of Medical Education.

The TREASURER.—I am glad to be able to say a few words with regard to Mr. F. J. Steward. In addition to the honors he has taken at the London University and mentioned in the Dean's report, he has taken the Gold Medal in Medicine and the Gold Medal in Surgery given by the Treasurer, and also the Beaney prize in Pathology. To-day, I am sorry to say, he is prevented from being present, being again in examination, but I am sure he has your sympathies and best wishes that in the ordeal he is now undergoing he may take an equally distinguished position.

The Prizes and Certificates were then distributed as follows:—

The Treasurer's Gold Medal for Clinical Medicine.—Francis James Steward, Old Charlton.

The Treasurer's Gold Medal for Clinical Surgery.—Francis James Steward, Old Charlton.

Gurney-Hoare Prize for Clinical Study.—Arthur Henry Leete, Wellingborough.

Beaney Prize for Pathology.—Francis James Steward, Old Charlton.

Sands Cox Scholarship for Physiology.—George Ernest Richmond, Leicester, Prize, £15; Harold Wilson Bruce, Bow, Prox. Accessit; Philip Turner, Earl's Court Gardens, Certificate.

Michael Harris Prize for Anatomy.—Frederick Edward Walker, Hampstead, Prize, £10; Harold Wilson Bruce, Bow, Prox. Accessit.

The Arthur Durham Prizes for Dissection.—First Year's Students.—John Tyley Montgomery McDougall, Saxmundham, Prize, £5; Russell Henry Jocelyn Swan, Camberwell, Certificate; John Dell Bridger, Cricklewood, Certificate; Walter Bernard Secretan, Croydon, Certificate. Second Year's Students.—Frederick Edward Walker, Hampstead, Prize, £15; Vincent James Crawford, Blackheath, Certificate; Lionel Edwin Charles Handson, Hampstead, Certificate; Laurie Hugh McGavin, London, Certificate.

Third Year's Prizes.—Robert Pugh Rowlands, Towyn, First Prize, £25; Robert Howard, Buckhurst Hill, Second Prize, £10; Edmund Ivens Spriggs, Market Harborough, Certificate; Charles Thompson Anderson, Certificate; John Thomas Roberts, Llanfachreth, Certificate.

Second Year's Prizes, 1894.—Edmund Ivens Spriggs, Market Harborough, and Robert Pugh Rowlands, Towyn, equal, £17 10s. each. Dental Students, 1895.—Joseph Lewin Payne, Kennington Road, Prize, £15; Edward Claude Dimock, Waterbeach, Certificate; Harold Dewe Matthews, Cheltenham, Certificate.

First Year's Prizes, 1894.—Philip Turner, Earl's Court Gardens, First Prize, £50; George Ernest Richmond,

Leicester, Second Prize, £25; Harold Wilson Bruce, Bow, Certificate; William Taylor Milton, Blackheath, Certificate. Dental Students, 1895.—Kenneth Weldon Goadby, Reading, and Norris Snell, Forest Hill, equal, £5 each; Arthur George Grant Plumley, Bristol, Certificate; Edwin Ernest Darley Heesom, Redhill, Certificate; Guy Chatterton, Peckham, Certificate.

Practical Dentistry Prize.—Edwin Claude Dimock, Waterbeach, Prize, £10.

Open Scholarships in Arts.—Arthur Pearson, Brixton, £100; George William Hare, Hastings, £50. Dental Students.—Guy Chatterton, Peckham, £30.

Open Scholarships in Science.—Thomas Francis Rutter, Balham, £100; John Thomas Dunston, Farnham, £60; Francis William Brook, Peckham, Certificate.

THE WORSHIPFUL MASTER OF THE SALTERS' COMPANY.—Mr. Treasurer, the authorities of this great Hospital have done me great honour in asking me to preside over this important meeting. I should like to try and bring before you the financial position of this Hospital. If you will kindly refer to the programme, on the last page but one appears a statement of facts to which I will refer. It appears therefrom that owing to the depressed state of agriculture, the financial position of this institution has become very grave; and even while thus embarrassed the authorities have felt compelled to try and keep abreast of the times by meeting the ever-increasing demands of science, the ever-increasing care demanded by public opinion in the treatment and nursing of the patients—a care which I am sure has always been considered, if not forestalled, by the authorities of Guy's Hospital. I think if the people of London only knew that such an institution as this, working in the midst of a population of one and a half millions, was so sorely pressed, they would not need to be asked to pour money into its coffers. The work of this Hospital has been going on for 171 years so quietly that it reminds one of the work of Nature.

> One lesson, Nature, let me learn of thee;
> One lesson which in every wind is blown;
> One lesson of two duties kept at one,
> Though the load would proclaim their enmity.
>
> Of toil unsever'd from tranquility,
> Of Nature that in lasting fruit outgrows
> Far noisier schemes accomplished in repose,
> Too great for haste, too high for rivalry.
>
> Yes, while on earth, a thousand discords ring,
> Man's fitful uproar mingling with his toil,
> Still do they, sleepless ministers, move on
> Their glorious tasks in silence perfecting.

I think that represents very much what this Hospital has been doing, and in these scrambling times, when clamourous people get everything, it is well to remind you of the good that is being done here in such a quiet way. I hope that all now present will respond to the appeal I am now making, for I should be pleased to think that in presiding on this occasion I had done some little good in forwarding the work of this institution. On this occasion we are all bimetallists, we shall be very pleased to take either your silver or your gold, and I am quite sure that the Treasurer would like to receive a collection of autographs, especially those of H. G. Bowen. You can get one for £5 or for £1000, and the larger the sum the better the Treasurer will like it. I do not think I shall be saying anything that your President would be offended at if I remark that on this occasion Mr. Hucks Gibbs would prefer the gold standard. It is also my pleasant duty to address a few words to the students. I saw, as I came through the colonnade, a number of young men full of life and hope, either passing the curriculum or passing out into the world to follow their noble vocation, and I trust they will follow it with honour to themselves and to their Hospital: it seems to me that this most honourable profession gives scope to the wise and strong to help the poor and weak in a way no other profession can, and I for one, recognise that the profession has carried out its great duty as perfectly as anything can be done in this world. Those who are passed middle life cannot help recalling from their own experience the kind sympathy and assiduous attention of the doctor when they have been watching their nearest and dearest passing through the crisis of a serious illness, and I have often been struck by the patient attention that the physician has given to details, which must have wearied him, which were very unnecessary and often irrelevant. Although the medical profession does not, and perhaps cannot receive the same kind of honour which is bestowed on the profession of arms, yet we must not forget that in the ordinary routine of their duty, doctors have often to face risks not less than those of the leaders of a forlorn hope, and we know some have sacrificed their lives in the pursuit of knowledge, for their love of science, and their love of humanity. I should like, if I may take the liberty, to warn the young men commencing their career, that they must expect rebuffs and disappointments as well as a share of the trouble and sorrow common to us all. I would advise them, in order to meet all this, to train themselves to face sorrow as a friend, to meet her with a cheerful heart, and an even mind, so that when the sorrow has passed, it may leave the man perfected to an extent, and enable him to sympathise more with the troubles of others. And it is a great help, in an arduous profession like the medical, to try and see the quaint side of nature, it will be a great help to yourselves, and to your patients, because it will cheer and help them along, and there is much in being cheered and helped along during illness. And it is well for you to take up some hobby outside your professional work. I notice that you are pre-eminent in athletics; and here in London, we are so well situated for the cultivation of every sort of hobby. We have the river—a never ending source of enjoyment—we are within easy reach of lovely country, and it seems to me there is no much better relaxation than walking over the country and enjoying the prospect during such weather as this; it sends you back to your work with renewed

vigour and cheerfulness, and in conclusion I will wish you all a cheerful heart, wise content, an even mind, good health and success in following your profession.

The paths of pain are thine. Go forth
With patience, trust, and hope.
The suffering of a sin sick earth
Shall give thee ample scope.

Beside the unveilled mysteries
Of life and death go stand,
With guarded lips and reverent eyes
And pure of heart and hand.

The TREASURER.—I am sure you will join with the Governors in thanking the Master of the Salters' Company for his presence and his speech. Our founder, Thomas Guy, was much attached to City Companies. He was a member of the Stationers' Company, and in a very old newspaper which was sent me the other day I read an account of how his funeral started from the Mercers' Company, and we are very anxious to continue those relations. The Worshipful Master has described to you the condition of this Hospital, and spoken also to the students. Now, the School and the Hospital are indivisible, and unless the Hospital is free our students must diminish in number. Unless the students can find opportunities for learning their work the number of students will be affected throughout London, and that means not only that the poor will suffer, but that there will be fewer physicians and surgeons at your beck and call when you are ill. During the past year we have had in this Hospital our successes and disappointments and our sorrows, and I know of no sorrow which touches us all so closely as the loss of our distinguished Consulting Surgeon, Mr. Arthur Durham. He took an extreme interest in everything connected with the Hospital. In the work and the play and all that went on he was always ready with heart, hand and purse to do what he could, and I am glad to think that a response has been made to the appeal to perpetuate his memory by the founding of two beds in this Hospital. Already we have raised upwards of one thousand pounds, which will pay for one bed, and now we have the second thousand to raise. I do feel that none of those old Students or Governors who had the privilege of knowing Mr. Durham will withhold their contribution to this great object, for we shall be perpetuating the memory of a man who was very precious to us all.

Dr. PYE-SMITH.—You, Sir, represent one of those ancient and illustrious bodies which in the past were so intimately connected with English industries and civil life, and which bore no little part in making England what she now is. But times have changed, and not many years ago it was said that the usefulness of those institutions had ceased, and that little remained but their wealth. We know there are many who, when wealth is reported to be present, at once break the ninth commandment, and before long will proceed backward as far as the eighth, and will find some scheme which shall be legal for relieving those encumbered with too much wealth. Such schemes have threatened many of those ancient companies, and it would have been easy to have destroyed or confiscated their wealth. Destruction of that kind can be performed by an infant or a madman, but to reform such great institutions, and to adapt to the needs of the present day that which was suited to the wants of the fourteenth or fifteenth centuries—that is a task which demands some manly courage, some common sense, some tact, some enthusiasm, some devotion. That is a task which, I believe, has been achieved by some of the bodies in question, for besides those we find supporting great public schools, there are two companies which I know deserve well of the profession to which I belong. One is the Grocers' Company, which expends £1,000 per annum in promoting investigation into the science of Preventive Medicine, and the other is the Company over which you, Sir, preside, and which has come to the help of this illustrious Hospital, and has endowed beds which might otherwise have been lost to the poor. For that we thank you most earnestly, and think you will have no cause for regret hereafter at such a just and wise distribution of your wealth, for these beds will be known as the "Salters' Company's Beds." Let me also thank you for the wise and helpful language you have addressed to our students. All the teachers of this School are proud of our students. We find them most eager to learn, ready for all good work, always at hand to look after infirm old men and women and children, to carry them down here for light and air, and in every way to spend themselves in the interests of those entrusted to their care; and, finally, I congratulate Messrs. Collins, Leete, and Steward upon the lustre they have this year shed upon their Alma Mater.

Mr. HOWSE.—I join most heartily in this vote of thanks to the Master of the Salters' Company for his kindness in presiding here to-day. Many years ago I had very good reason to be well acquainted with the liberality of the present Master in his various dealings with the poor of London, and now we find him taking the chair to-day on account of his connection with the great Company which, by an annual subscription of £250, has prevented five of our beds being closed. We hope that the very deplorable prospect which is opened out to us by the report in the programme may be averted, and as we were told it was necessary to be clamorous to get funds, I feel it also necessary to be so in a special way. Guy's Hospital is in distress. We are £20,000 a year to the bad, and we want £20,000 a year somehow or other. Well, 2,000 annual subscriptions of £10 a piece would do it. That is perhaps a large order you may think, but not so when it is considered what the wealth of this great City is, and what the wants of South London are. Now there are very special reasons it seems to me, why this Hospital should be supported in distinction to certain other institutions. We all see in the newspapers of the opening of new hospitals, and the other day there

came a suggestion for the building of one at Camberwell; and all this while we have wards here closed simply for the want of funds to keep them open. Now, as Mr. Bryant has pointed out, these wards can be made subservient to the use of the whole of South London; and you will all see that, as we have the plant here and have wards already erected, and have the nursing and domestic staff already here, the work can be done more cheaply than anywhere else. As an illustration we will take the fact that this £250 per annum has sufficed to endow five beds, and £1000 each will endow the "Durham Beds." Now, you cannot suppose that in any newly-constructed hospital £50 would in any way correspond with the cost per bed for a year. Very far from it, indeed, I can assure you; but here we can fairly open beds on that sum, because the general expenses of maintaining the fabric and hospital system are already met. So it is an exceedingly advantageous time for the endowment of beds. It can be done now at the rate of £1000 per bed, because we have all the material ready. I do most earnestly hope that you will spread abroad the information of the needs of Guy's Hospital. Some years ago there was an organization in the sister island called "Spread the Light Fund." I want you to take that to heart to-day, and all be centres for spreading the light, and the light is that Guy's Hospital is in distress; that we can do things more cheaply here than elsewhere; that we want money, and must have it if the usefulness of this Hospital is to be maintained; and that the poor of South London will suffer very grieviously if it is not forthcoming.

The Bishop of Southwark.—Nothing makes me more miserable than to be called upon to make an unexpected speech. I came here to enjoy a happy afternoon by way of witnessing those coming men, the students of this place receive their prizes and certificates, and I desired one other thing: as far as my presence could do it, to signify the very great debt which all this south side of London owes to the two great hospitals of St. Thomas' and Guy's. It is a pleasure to me to think that both of these take their origin from that place from which I have the honour to take my name. Speaking as a "slum and dirty" Bishop, I do not know what the poor people round here would do without that constant running to and fro to Guy's Hospital, which, perhaps you will say they do on the slightest provocation: but I feel sure that all those who love the poor and all those who look at this thing from a religious as well as a philanthropic point of view will do their best to make those empty wards again full and prosperous. I suppose I am to speak, because in a sense I represent also a great faculty of wholesomeness and healing. My faculty is the soul, yours is the faculty of the body, and he is a poor thinker, certainly a poor observer of the movements of the human mind or body whoever supposes that those two can be divorced. Certainly I, speaking as a doctor of the soul, know that a great deal of the disease I have to treat has intimate relation to the body, and never would I be able to make my diagnosis and apply a proper remedy unless I stopped to think of that man's body. And you on your part may concede that often you will be unable to treat successfully the disease of the body unless you have thought of the influences of the mind and of the soul upon that body. So these two great sciences of religion and medicine go hand-in-hand. May they ever do so, and when that great Collegiate Church on the other side of the road is open, and begins to do its work in Southwark, my hope is that again, as in ancient days, it may send out its utmost benevolence to assist the great science of medicine, and you, on your part, will not forget that we are your brother ministers, and you will work with us for the salvation of body and soul. I speak out of the very fulness of my own desire, that there may flourish here in South London for the benefit of the poor, as well as of the rich, the fullest opportunities for the sciences of religion and medicine.

The vote of thanks having been unanimously passed, and suitably acknowledged by the Worshipful Master, the proceedings closed.

The Arthur Durham Memorial.

It is proposed to raise a fund of £2000 to endow in perpetuity Two Beds in memory of the late Mr. Arthur E. Durham. In gratefully acknowledging the following second list of subscriptions, the Collecting Committee, in view of the fact that nearly £800 still remains to be subscribed, make an earnest appeal for further subscriptions. To complete the fund within the next fortnight means a big effort, but not an impossible one if all who contemplate subscribing will now do so in as liberal a manner as possible.

	£	s.	d.
Amount previously acknowledged ...	653	1	0
Brailey, W. A., Esq., M.D., Old Burlington Street	10	10	0
Ticehurst, A. R., Esq., St. Leonards ...	10	10	0
Rothschild, The Hon. W., New Court ...	10	10	0
Laidlaw Purves, W., Esq., M.D., Stratford Place	5	5	0
Hall, J. G., Esq., J.P., Swansea	5	5	0
Barclay, C., Esq., Bishopsgate Street ...	5	5	0
Debus, H., Ph. D., Cassel, Germany... ...	5	5	0
Smith, O., Esq., Eaton Square	5	0	0
Acland, Bart. Sir T. D., Exeter	5	0	0
Martin, H. A., Esq., M.D., Lympstone ...	4	4	0
Lund, E., Esq., F.R.C.S., Manchester ...	3	3	0
Eastes, G., Esq., F.R.C.S., Gloucester ...	3	3	0
Burghard, F. F., Esq., F.R.C.S., Weymouth Street	3	3	0
Turner, J. Sidney, Esq., Upper Norwood ...	2	2	0
Hamilton, E. T. E., Esq., M.D., Forest Hill	2	2	0
Bisshopp, Francis R. B., Esq., M.A., M.D., Tunbridge Wells	2	2	0
Blaker, W. C., Esq., M.D., Bognor	2	2	0
Weaver, F. P., Esq., M.D., Hampstead ...	2	2	0
Burgess, W. F. R., Esq., M.D., Streatham ...	2	2	0
Hopson, Montagu F., Esq., Hampstead ...	2	2	0
Taylor, W. Bramley, Esq., Denmark Hill ...	2	2	0
Audland, W. E., Esq., Wellingborough ...	2	2	0
Maggs, W. A., Esq., Hanover Square ...	2	2	0

	£	s.	d.
Puzey, Chauncey, Esq., F.R.C.S., Liverpool	2	2	0
Paul, F. T., Esq., Liverpool	2	2	0
Faulkner, J. J., Esq., LL.D., Dallington ...	2	2	0
Ash, R. F., Esq., 42, Southwark Street ...	2	2	0
Burghard, Mrs., Weymouth Street	2	2	0
Davies, A., Esq., M.D., Newport	2	0	0
Nash, W. G., Esq., Rugby	1	1	0
Roberts, H. J., Esq., Pen-y-groes	1	1	0
Frazer, E., Esq., Jersey	1	1	0
Knaggs, R. L., Esq., M.D., Leeds	1	1	0
Green, A., Esq., M.D., Chesterfield	1	1	0
Garrett, A. E., Esq., Rickmansworth ...	1	1	0
Chubb, W. L., Esq., Sandgate	1	1	0
Landon, E. E. B., Esq., Woodford	1	1	0
Moore, W. H., Esq., Kidderminster ...	1	1	0
Tanner, J., Esq., M.D., Queen Anne Street..	1	1	0
Pearson, H. A., Esq., Inkberrow	1	1	0
Mason, W. I., Esq., Sudbury	1	1	0
Briscoe, J. F., Esq., Alton	1	1	0
Hind Wheeton, Esq., M.D., Stoke-on-Trent	1	1	0
Humphreys, F. W., Esq., West Kensington Park	1	1	0
Caldecott, C., Esq., M.B., Bracknell ...	1	1	0
Lockwood, J. Parker, Esq., Faringdon ...	1	1	0
Fleury, C. M., Esq., Netley	1	1	0
Williams, A. H., Esq., M.B., St. Leonards...	1	1	0
Rawlings, J. A., Esq., Swansea	1	1	0
Dalton, C. B., Esq., Derby	1	1	0
Martin, D. A. W., Esq., Guy's	1	1	0
Spurrell, C., Esq.,, F.R.C.S., Homerton ...	1	1	0
Beadnell, C. M., Esq., Guy's	1	1	0
Norman, A., Esq., Hunstanton	1	1	0
Minns, P., Esq., M.D., Thetford	1	1	0
Daldy, A. M., Esq., M.D., Kingston ...	1	1	0
Roberts, E. C., Esq., Southgate ...	1	1	0
Shelswell, O. B., Esq., Mitcham	1	1	0
Budge, E. J. H., Esq., Fulham	1	1	0
Coulson, J. E., Esq., Fulham	1	1	0
Hore, Surg.-Capt. H. St. G., Aldershot ...	1	1	0
Young, John, Esq., M.D., Stamford Hill ...	1	1	0
Donnelly, W. T. B., Esq., M.B., New Cross...	1	1	0
Toogood, Hill W., Esq., Enfield	1	1	0
Deane, A. D., Esq., Walthamstow	1	1	0
Berry, H. Poole, Esq., M.B., Grantham ...	1	1	0
Godson, A. H., Esq., M.B., Oldham	1	1	0
Roberts, C. G., Esq., M.B., Halstead ...	1	1	0
Musgrave, J. T., College Terrace	1	1	0
Kingscombe, A. P., Esq., Towcester	1	1	0
Holman, H. J., Esq., Eastbourne	1	1	0
Sanders, J. W., Esq., M.D., Broad Clyst ...	1	1	0
Woodruff, J. W., Esq., Reading	1	1	0
Jackson, P. J., Esq., Great Dover Street ...	1	1	0
Hodge, W. T., Esq., Baschurch	1	1	0
Philipps, A. E., Esq., Guy's Hospital ...	1	1	0
Williams, W. W., Esq., St. Davids	1	1	0
Allport, A., Esq., Milk Street Terrace, E.C....	1	1	0
Shillitoe, A.,Esq.,F.R.C.S., Frederick Place, E.C.	1	1	0
Price, J. A. P., Esq., M.D., Reading... ...	1	1	0
Buchanan, A., Esq., M.D., Chatham ...	1	1	0
Willan, G. T., Esq., Melton Mowbray ...	1	1	0
Crew, John, Esq., Higham Ferrars	1	1	0
Abbott, G., Esq., Tunbridge Wells	1	0	0
Per Miss Hickson—			
Berger, Mrs. M. A., Woodford	50	0	0
Irving, Sir Henry, The Lyceum Theatre ...	26	5	0
Peek, Bart. Sir H., Eastcheap	26	5	0
Montefiore, Mrs. N., 18, Portman Square ...	26	5	0
De Vesian, Mrs., Nutfield	10	10	0
Dodd, G. Ashley, Esq., Bath	10	10	0
Croft, J., Esq., Mansfield Street	10	10	0
Foster, C. F., Esq., Pinehurst, Cambridge ...	10	10	0
Lindley, Mr. and Mrs. Robt. H., Swansea ...	10	10	0
Wren, Walter, Esq., Powis Square	10	0	0
Repton, G., Esq., Curzon Street	10	0	0
Duncamp, Mrs., Gard, France	10	0	0
Lyne, H., Esq., Regent Street	5	5	0
Montefiore, C., Esq., Portman Square ...	5	5	0
McIver, Mrs., Upper Brook Street	5	5	0
Schulhof, Mrs., Palace Gardens Terrace ...	5	5	0
Speer, Mrs. Stanhope, Ventnor	5	5	0
Stedall, H., Esq., Hampstead Heath ...	5	5	0
Jeakes, J. W., Esq., Great Ma vern	5	0	0
Jones, D., Esq., Wimbledon	5	0	0
Dickson, Col. W. B. B., Reading	5	0	0
Jones, Miss F. H., Steeles Road	3	3	0
Hilton Fagge, The Misses, Guernsey ...	3	3	0
Trustees of Stockwell Orphanage, The ...	3	3	0
Bodkin, W., Esq.	3	3	0
Burt, George, Esq., Westminster	3	3	0
Speer, Miss, Ventnor	3	3	0
Waterlow, Sir Sydney, Chesham Place ...	3	3	0
Sterling, Miss F., 18, Sheffield Terrace ...	3	0	0
Mallett, Miss, Highbury	3	0	0
De Vesian, R. E., Esq., Crown Court, E.C....	2	2	0
De Vesian, J. E., Esq., Crown Court, E.C. ...	2	2	0
Walters, Laundy, Esq., Wimbledon... ...	2	2	0
Porter, H. W., Esq., Inverness Terrace ...	2	2	0
Bulmer, E. F., Esq., Credenhill	2	2	0
Hay, Mrs.	2	2	0
Whyte, Mrs. R.	2	2	0
Patterson, Miss N. G., Holywood, Co. Down	2	2	0
Waterlow, Mrs., Strathrey House	2	2	0
Lubbock, Sir John, Farnborough	2	2	0
Toole, J. L., Esq., Maida Vale	2	2	0
Hickson, F., Esq., Old Charlton	2	2	0
Samuelson, N., Esq., Streatham	2	2	0
Speer, C. T., Esq., Sutton	2	2	0
Lucas, A., Esq., New Bond Street	2	2	0
Stevenson, Mrs., 33, Devonshire Place, W.	2	2	0
Stoker, Bram., Esq., The Lyceum Theatre...	1	1	0
Bates, Mrs., Fellowes Road, W.	1	1	0
Joysey, Revd. C., Finchley Road, N.W. ...	1	1	0
Motiram, Madame, S. Advani	1	1	0
Hill, A., Esq., Birmingham	1	1	0
Riviere, Miss C., St. John's Wood	1	1	0
Pym, C. Guy, Esq.	1	1	0
Hoxley, Mrs., Reading	1	1	0
Coales, Mrs. M., Chingford	1	1	0
Sargant, Mrs., Redhill	1	1	0
Repton, Guy, Esq., Curzon Street	1	1	0
Stirling, A., Esq., Cambridge Terrace ...	1	1	0
Gray, S. O., Esq., Belsize Park Gardens ...	1	1	0
Benicke, Miss Ida, Canfield Gardens ...	0	10	6
Brewer, Miss A.	0	2	6
Per A. P. Allan, Esq., Guy's Hospital.—			
Elcum, Surgeon-Major	2	2	0
Handley, W. S., Esq.	1	1	0
Allan, A. P., Esq., M.B.	1	1	0
Allan, Mrs. John	1	1	0
Pendred, Vaughan, Esq.	1	1	0
Manning, G. E., Esq., M.B.	0	5	0
Askew, C. A. C., Esq.	0	5	0
Horton, J. H., Esq.	0	5	0
Carden, W. A., Esq.	0	3	0
Evans, C. R., Esq.	0	2	6
Per T. M. Walker, Esq.—			
Walker, T. M., Esq.	0	10	0
McGavin, L. H., Esq.	0	10	0

	£	s.	d.
Handson, L. E. C., Esq.	0	5	0
Thornely, M. H., Esq.	0	5	0
Thomas, W. R., Esq.	0	2	6
Starling, H. J., Esq.	0	2	6
Per H. Millson, Esq.—			
Millson, H., Esq.	5	5	0
Dawes, Mr. and Mrs. G.	2	2	0
Shuter, D. T., Esq.	1	1	0
Field, T., Esq.	1	1	0
Hagg, H., Esq.	1	1	0
Gabb, H., Esq.	1	1	0
Turpin, W., Esq.	1	1	0
Holborrow, W., Esq.	1	1	0
Jeffreys, Messrs. J.	1	1	0
Per C. E. Carpmael, Esq.—			
Anderson, Webber & Small, Messrs.	3	3	0
Rowland, J., Esq.	2	2	0
Carpmael, F., Esq.	1	1	0
Carpmael, C. E., Esq., M.B.	1	1	0
Bevan, O., Esq.	1	1	0
Every-Clayton, L. E. V., Esq.	1	1	0
Rowland, W. J., Esq.	0	10	6
Moffat, H. A., Esq.	0	10	0
Fortescue-Brickdale, J. M., Esq.	0	5	0
Anderson, C. T., Esq.	0	5	0
Hills, E. C., Esq.	0	2	6
Ashwin, R. N., Esq.	0	2	6
Lidderdale, F. J., Esq....	0	2	6
Godson, F. A., Esq.	0	2	6
Per T. M. Nicholson, Esq.—			
Orr-Ewing, M. H., Esq.	5	5	0
Nicholson, Marshall, Esq.	5	5	0
Wagg, H., Esq.	1	1	0
Nicholson, W., Esq.	1	1	0
Nickols, H., Esq.	1	1	0
Conyers, F., Esq.	1	1	0
Garnett, J., Esq.	1	1	0
Wardall, F., Esq.	1	1	0
Busteed, J. H., Esq.	1	1	0
Biggs, J. J. E., Esq.	1	1	0
Peake, W. H., Esq.	1	1	0
Stevens, T. G., Esq., M.D.	1	1	0
Munro, H., Esq..	1	1	0
Loud, F., Esq.	1	1	0
Harris, W. J., Esq., F.R.C.S.	0	10	6
Delbruck, R. E., Esq.	0	10	6
Bryant, C. H., Esq., M.B.	0	10	6
Hepworth, W., Esq.	0	10	6
Alexander, H., Esq.	0	10	6
Francis, C. J., Esq.	0	10	6
Dudgeon, H. W., Esq.	0	10	6
Milward, W. C., Esq.	0	10	6
Rowland, F. W., Esq.	0	10	6
Ramsden, W., Esq.	0	10	6
Rowland, R. S., Esq.	0	5	0
Stead, C. C., Esq.	0	5	0
Mathison, A. J., Esq.	0	5	0
Jephcott, C., Esq.	0	5	0
Butler, A. G., Esq.	0	5	0
Reynolds, L. G., Esq.	0	5	0
Booker, C. W., Esq.	0	5	0
Pearse, A. S. J., Esq.	0	2	6
Finch, A. H., Esq.	0	2	6
Way, M. H., Esq.	0	2	6
Morgan, C. P., Esq.	0	2	6
Simson, H., Esq.	0	2	6
Jones, M. P., Esq.	0	2	6
Richardson, J. J. D., Esq.	0	2	6
Cleveland, A. J., Esq.	0	2	6
Fitz-Hugh, R. T., Esq....	0	2	6
Per F. J. Steward, Esq.—			
Sister Luke	3	0	0
Beddoe, D. M., Esq., F.R.C.S.	1	1	0
Jackson, Y., Esq., Whitehaven	1	1	0
Sister Martha	1	1	0
Collins, Y. E., Esq.	1	1	0
Clarke, W. T., Esq.	0	10	0
Beddard, A. P., Esq.	0	10	0
Beach, H. W., Esq.	0	10	0
Sister Accident	0	10	0
Todd, D. B., Esq.	0	10	0
Garland, J. O.	0	10	0
Shorland, E. T., Esq.	0	7	0
X	0	5	0
Hodgson, C. R., Esq.	0	5	0
Peatson, J. C., Esq.	0	5	0
Wood, W. R., Esq.	0	5	0
Anon	0	5	0
Wakefield, C. F., Esq.	0	5	0
Jackson, T. L., Esq.	0	5	0
Temple, P. G., Esq.	0	2	6
Hedden, R., Esq.	0	2	6
Ta'Bois, F. W., Esq.	0	2	6
Parfitt, J. B., Esq.	0	2	6
Sister Job...	0	2	6
Sister Philip	0	2	6
Sister Cornelius...	0	2	6
Thomas, T. M., Esq.	0	2	6
Smith, D. L., Esq.	0	2	6
Hicks, H. T., Esq.	0	2	6
	£1,234	12	6

Review.

The Eye in Relation to Health. By Chalmers Prentice, M.D., Chicago. (Bristol: John Wright & Co.) Price 6s. 6d.

The author evidently anticipates adverse criticism, and therefore commences his book with an account of the qualifications he considers that a reviewer should possess if his remarks are to have any value. He then proceeds to unfold his theory with regard to diseases in general, which, briefly stated, is the following: All diseases are due to some interference with the action of "nerve-force" (*sic*); any defects in the eye muscles necessitating the undue expenditure of "nerve-force" in their innervation will produce disease, and the cure of the defect will therefore put an end to the disease. Following out these views in practice, Dr. Prentice professes, by the successful treatment of "latent" defects in the muscalature of the eye, to have cured Phthisis, Diabetes Mellitus, Chronic Bronchitis, Hemiplegia, etc. Enough has been said to show that at parts the book is decidedly surprising, and in fact in reading the book it is difficult sometimes to believe that the author means it to be taken seriously. Despite the fact that the illustrative cases are as a rule too imperfectly described to be of any real value, still there is a good deal of information incidentally given, and the book further possesses the interest which always attaches to works dealing with "faith-cures."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

United Hospitals' Boxing Club.

DEAR SIR,—Although the Inter-Hospital Boxing Competition was held rather late this season it was fully anticipated that it would be a success; unfortunately, this has not proved so. The Club has suffered financially, and is now about £10 on the wrong side. If this deservedly popular institution is to continue its career of usefulness in the future this deficit must be cleared off. May I, therefore, through the medium of the GAZETTE, appeal to all Guy's men to help us to raise a *portion* of this sum? The smallest donations will be gladly received and acknowledged by me.—Yours faithfully,

G. E. DUNCAN,
Hon. Sec., Guy's Hospital Boxing Club.

The Bermondsey Settlement.

DEAR SIR,—Will you allow me space in your columns to make a special appeal to Guy's men for help in connection with the educational work of the Bermondsey Settlement. Our buildings in Farncombe Street are close to Spa Road Station, and therefore within easy reach of the Hospital. We are in need of teaching in Ambulance, in Elementary Chemistry, and in one or two other branches of Physical Science, and help in some of our Gymnastic Societies, would be very valuable to us. I know that the demands upon Medical Students are so heavy that it is impossible to ask them to devote much time to such work, but the help that I ask for would only occupy an hour or two a week, and while it would satisfy the desire of many to render some direct social service, it would be of great advantage to those who gave it in increasing their knowledge of the mental and social conditions of the people whom they taught. Mr. F. G. Hopkins, Demonstrator in Chemistry at the Hospital, is interesting himself in this matter, and is kindly willing to give information to any who are inclined to assist us.

I may add that we have two or three vacancies for residents at the Settlement, and we shall be glad to see any who may be inclined to make trial of life in a community like ours. Those who have already done so, have found that it is perfectly possible to combine comfort, study and freedom with the active interests for enterprises which are both broad and unsectarian. Our terms are very moderate, and I think that I may claim that the convenience of residents is carefully considered in the management.

Thanking you for your kindness in inserting this,—I am, yours faithfully,

J. SCOTT LIDGETT.
Warden of the Bermondsey
University Settlement.

July 3rd, 1895.

The Condition of the Papers in the Club.

DEAR SIR,—During the last month or so there have been numerous complaints to us about the condition of the magazines and newspapers in the Smoking-room.

The chief causes of complaint have been the difficulty of finding magazines in their proper cases, and the illegible condition of them when found. The first of these has been due to the destruction of the cords belonging to the cases, and to the carelessness of certain members in not putting the magazines back when once out. The cases are now being repaired, and it is hoped that there will be no more complaints from this cause. The second cause of complaint is sometimes due to carelessness, at other times to deliberate cutting out of the contents of certain magazines and newspapers. We could give many instances of this.

We therefore appeal to members to look better after their own interest, as it is obviously impossible for any sub-committee to do anything without their co-operation. We are, etc.,

THE NEWSPAPER SUB-COMMITTEE.
Students' Club.

The Meeting of the B.M.A. in London.

SIR,—There will no doubt be a large attendance of old Guy's men at the approaching British Medical Meeting, and any facilities which can be given for old friends to spend some portion of the week together, would be very welcome. It has occurred to me, that, as the Summer Session will just be over when the Medical Meeting begins, it might be possible for the authorities at Guy's to place some portion of the College at the disposal of old Guy's men. Possibly they might be allowed to breakfast together, and it may even be that some of the rooms could be let to them, so that a few could enjoy the pleasure of again sleeping under the old roof, with the possibility of seeing an operation done during the night hours. I hope, too, that the Staff will make such arrangements that old Guy's men may be able to go round the wards with them and see operations done at hours which will not clash with the sectional meetings.—I am, Sir, yours faithfully,

J. FARRANT FRY.

Shepton Malet, Somerset,
June 27th, 1895.

[Upon enquiry, we learn from the authorities, that a bedroom may be obtained in the College at the small cost of 2s. 6d. per night, and should he desire boarding as well, any old Guy's man who is a *member* of the Clubs' Union, will be able to obtain his meals in the Club, according to the usual tariff. Early application is necessary to prevent disappointment.—ED.]

MATERIA
MEDICA
The following
Gentlemen
have passed
37-39-44
46-50-55
61-62-67
72-77-78
79-83-87
88-95
A. Spinner

REJECTED !

Passim.

SPEECH DAY passed off in the pleasantest manner, and there was a very large company of visitors. For the most part our own students were, as usual, conspicuous by their absence; this is a state of things we should like to see remedied in the future. Strangers present on the occasion might go away with an impression that Speech Day at Guy's was the last thing in the world that the students were interested in. Among the company present, in addition to the Master of the Salters' Company and Mrs. Blackwell, and the Treasurer, were many of the Staff: Dr. Wilks, Dr. Braxton Hicks, Mr. Tom Bryant, the Lord Bishop of Southwark, Sir Henry Peek, Sir Joseph Fayrer, Sir Frederick Wigan, Mr. J. H. Fellowes, Mr. A. J. Lawrence, Lady Clifford, Rev. J. W. Horsley, Rev. J. S. and Mrs. Lidgett, the Misses Blackwell, the Matron, Dr. Galton, Dr. J. Ince, Dr. and Mrs. McManus, Mr. and Mrs. Craggs, Dr. and Mrs. Alexander, Rev. E. Shore, Rev. and Mrs. C. H. Bowden, Rev. and Mrs. Edwards, Rev. T. Gage Gardiner, and many others.

THE occasion was marked for the enthusiasm displayed over the appeal on behalf of this great Institution, and it is very gratifying to know that this has already borne fruit. We heard of several promises to the Durham Memorial, and the Master of the Salters' Company, before leaving the Hospital, left a donation of £20 from himself, and £5 from Mrs. Blackwell, graciously signifying his intention of becoming an annual subscriber to the Hospital. We hope his generous example will be speedily followed by others. In this connection, perhaps the most forcible appeal was made by the striking notices which met the eye of visitors as they entered Addison and old Mary wards for tea—

"THIS WARD IS CLOSED
FOR WANT OF FUNDS."

Is it too much to hope that it will not be necessary to make this announcement next year?

FOR the clever cartoon which we publish to-day we are greatly indebted to Mr. William Parkinson, one of the staff of *Judy*. Mr. Parkinson has a considerable reputation as a caricaturist, and some specimens of his artistic black and white productions are exhibited this year in the Royal Academy. We are, therefore, greatly favoured by his kind contribution.

ALL Guy's men will learn with regret that our esteemed lecturer of Public Health, Mr. George Turner, will shortly sever his connection with the Medical School. At the same time, the announcement of his appointment as Medical Officer to the Government of the Cape of Good Hope will have been received with universal satisfaction. On Thursday last Mr. Turner's numerous friends and neighbours of Broxbourne entertained him at dinner at the Great Eastern Hotel.

An opportunity will be afforded to Guy's men of showing their appreciation and regard for Mr. Turner by taking part in the complimentary dinner to be given to him at Limmer's Hotel on Saturday next, July 13th. Dr. Pye-Smith has consented to take the chair, and Mr. Symonds has kindly undertaken to make all the necessary arrangements. Guy's men desirous of attending should, therefore, communicate with the last-named, who will be pleased to secure seats, etc. In our next issue we hope to give an account of the dinner, with a full notice of Mr. Turner's career since he entered Guy's as a student about twenty-five years ago.

ANY member willing to read a Paper before the Physical Society during the next session, is requested to communicate his desire in writing to one of the secretaries of the Society without delay, that the sessional programme may be arranged as soon as possible.

THE Annual Dinner of the Debating Society took place in the Reading-room of the Club on the 27th ult., and was attended by some 30 members and visitors, Dr. Washbourn kindly occupying the chair. The Chairman, whose lot it is on this occasion to choose the subjects for debate, announced them to be—"That the Rugby game of Football is alike injurious to mind and body, and that it encourages the worst passions in the minds of players and spectators, that it is dangerous to life and limb, and that it should be abolished from civilised communities;" and, "That in the opinion of this House experiments upon animals are cruel and useless, and should be prohibited by law." Very amusing and entertaining debates took place on both subjects, but no division being allowed, no definite issue was obtained on either question.

WE greatly regret that a critical report of one of the debates which appeared in our columns, should have been made the occasion for an incident, happily unprecedented in the history of the Society. A special meeting was convened after the proceedings noted above had taken place, to consider the published report in question, the result being that what was practically a vote of censure was passed upon the ex-Secretaries. To do the objectors to the report under discussion justice, it is fair to say, that it was mainly pressure from the other side which brought about this undignified *coup*. We are strongly of the opinion that this step taken by the members—it may have been in a hasty moment—is a dangerous precedent, and one by no means conducive to the best interests of the honourable Society to which they belong. Dr. Washbourn directed the debate, which at this stage was maintained at some heat, with great firmness, as he did, indeed, throughout the difficult business meeting which took place earlier in the evening, and his resignation of the Vice-Presidency was received with very general regret.

THE election to the Council at the College of Surgeons on Thursday gave the following results:

Alfred Willett	415 votes.
Frederick Treves	326 „
Henry Trentham Butlin... ...	323 „
Alfred Cooper	295 „
John Ward Cousins	284 „
John Davies-Colley	249 „
Arthur Norton	247 „
Herbert William Page	237 „
William Anderson	210 „

Votes were received from 681 Fellows, and of these no less than 621 were sent through the post, while only 60 Fellows voted in person. Such is the result of the recent changes in the mode of election.

THE contest for the United Hospitals' Cycling Shield will take place on July 10th, at Herne Hill.

THE congregation of St. Andrew's, Stoke Newington, have again made their annual contribution to the funds of the Hospital, which amounted this year to the handsome total of £115 10s. 5d. As the sum received by Guy's from this congregation in 1886 was £40, it is quite evident that things are flourishing in the North of London. Would that they were in the South.

Our Portraits.

Francis James Steward.

BORN near Southampton, in 1872, and educated at Bedford County School, Mr. Steward soon showed expectation of an exceptional career. He obtained the Royal Agricultural Scholarship, the Junior Bennett Exhibition, and the Silver Medal for Science in 1888, and the following year the Senior Bennett Scholarship and the Silver Medals for Science and Mathematics. He entered Guy's in October of 1889, passed the Preliminary Scientific Examination in July, 1890, and obtained the Entrance Science Scholarship in the following October. His career hitherto has been one long round of success. He obtained the first prize for First Year's, Second Year's and Fourth Year's Students, the Beaney Prize in Pathology, and finally the Treasurer's Gold Medals in Medicine and Surgery.

(*From a photo kindly taken for us by* MR. H. T. HICKS.)

With such an unparalleled record in Hospital examinations, Mr. Steward has also won distinction for himself in the various professional examinations. In the Intermediate (M.B.) Examination of the University of London he gained a very high position in July of 1892, being awarded the Exhibition and Gold Medal in Organic Chemistry, and the Gold Medals in Anatomy and Physiology. In May of 1893, he received his first check at the Primary Fellowship Examination of the Royal College of Surgeons, but at the October examination for the degrees of M.B., B.S. London, he met with conspicuous success, and obtained First-class Honours in Medicine, Forensic Medicine, and Obstetric Medicine.

With all his brilliant achievements—scholastic and professional—Mr. Steward, in common with so many of

Guy's students, has always taken a keen interest in Hospital sport. At Bedford he gained reputation as an athlete and a swimmer of no mean order, and his keenness as a forward in the second fifteen at Guy's, materially helped towards the success of the team in the unbeaten season of 1891–2.

He is a Vice-President of the Physical Society, and served as its representative on the Council of the Clubs' Union, and in 1894 divided the Physical Society's prize for the best paper of the session with Mr. C. J. Harnett, his contribution being a most able and lucid dissertation on "Physical Exercise." In the midst of all his work he has found time and energy to devote himself to the best interests of the students; and we ourselves have felt his influence during the time he has served on the Gazette Committee. In other pursuits he was a volunteer, and served with the Artists' Corps. He is, on occasion, also an ardent yachtsman, and can sail a boat with the best of them.

Mr. Steward did six months dressing to Mr. Lucas, has occupied the post of Clinical Assistant and Assistant House-Surgeon during the first six months of the present year, and is now acting as House-Surgeon to Mr. Lucas. To have accomplished so much in the six years he has been at Guy's falls to the lot of few men, and it is as fitting as it is a graceful act that his remarkable achievements should receive early recognition. Mr. Steward's appointment as Demonstrator of Anatomy, which takes effect from October next, while it deprives the Surgical wards for three months of an eminently practical, efficient and popular House-Surgeon will, we feel confident, be of lasting good to the students in the Dissecting-room, and of infinite value to the Medical School.

Henry Acland Munro.

BORN in London in November, 1865, Mr. Munro was educated at Charterhouse, and entered New College, Oxford, in 1884. He took the B.A. degree with a 2nd Class in Physiology in 1888, and entered Guy's as a third year's student in October, 1890, having passed the Intermediate M.B. Examination in the previous July. He has held many of the appointments, and in June, 1894, took the degrees of M.A., M.B., B.Ch. of his University; the following month he obtained the diploma of the Conjoint Board. He was Clinical Assistant in 1893, Dresser in the Eye wards from July to October, 1894, Assistant House-Physician during the months of April, May and June this year, and is now House-Physician to Dr. Goodhart. These incidents in his career go far to prove that Mr. Munro has at no time followed his natural tendencies as an athlete to the neglect of his studies at Guy's Hospital.

In 1878 he ran his first race at Bromley, Kent, over a distance of 100 yards, but at Charterhouse in 1883 he won the School Mile in 4 min. 30 sec., which stands as the school record. In 1884 he was again the winner of the mile in 4 min. 47 sec.; and of the Oxford University Freshmen's Mile. During his six years at Oxford he was rarely fit, mainly owing to ill-health, but in 1886 he finished third in the Inter-University Three Miles at Lillie Bridge. At the Oxford University Sports, in 1888, he was third to F. J. K. Cross and W. Pollock Hill in the Mile, and second to Pollock Hill in the Three Miles. In the same year, at the Oxford and Cambridge Sports at the Queen's Club, he was beaten by Cross and W. B. Thomas in the Mile. His first race across country was in 1887, after which year he applied himself regularly to that branch of sport, running prominently in the 'Varsity Matches, while in 1892 he did one of his best performances in running second to E. C. Willers in the Essex Ten Miles Cross Country Challenge Cup, and in 1893 he was eighth

(*From a photo by* FRADELLE & YOUNG, Regent Street).

for the Lea Harriers in the Southern Counties' Championship. Repeated successes in the Lea Harriers and United Hospitals' Hare and Hounds' Ten Miles Challenge Cup races across country have also fallen to his share. On the flat, in the United Hospitals v. Edinburgh University match of 1892, he won the Three Miles in 14 min. 56⅘ sec. On June 25, 1892, a week before his memorable contest with Kibblewhite in the Four Miles Championship, he won the Mile Championship of Scotland; and on the 9th July of the same year finished second from scratch in the Open Mile at Beckenham, his time being 4 min. 26⅗ sec. For the L.A.C. against Oxford in both 1893 and 1894, he won the Three Miles in 15 min. 9 sec. and 15 min. 1 sec. respectively; and for Guy's, in the United Hospitals' Sports, has won the Mile and Three Miles five years in succession, in each of which race he holds hospital record.

Little more than a month ago, at the L.A.C. meeting, he aspired to the Club's Mile Challenge Cup, in company with such rivals as W. E. Lutyens and Harold Wade, and ran both these antagonists to a standstill in the splendid time of 4 min. 20⅖ sec., thus beating his previous best time by more than 6 sec. This was not the first time he had surprised his opponents, for in 1892, in the Four Miles Championship, he made a gallant struggle with Kibblewhite for premier honours, and although unsuccessful, he compelled the victor to do the fastest championship time of 19 min. 51⅗ sec. in order to win by a lead of only 4 yards. Recently, for the L.A.C. against Cambridge University, Munro defeated Horan in the Three Miles in 14 min. 48⅕ sec., and only the other day repeated this fine performance against the same runner for the United Hospitals, at Stamford Bridge, in the splendid time of 14 min. 48 sec.; this being his fastest time.

He has served on the Committee of the Guy's and United Hospitals' Athletic Clubs, was secretary of the former in 1891 and 1892, secretary of the latter in 1892, and captain in 1893. He was last year also a member of the Council of the Clubs' Union.

No runner can have taken part in so many matches with the Universities as Munro, and a complete record of his performances would show an extremely brilliant career. There is no athlete more modest, or more popular with his fellow competitors and the public. He will compete in the championships in July, in which contest his fellow students will join us in wishing him every success.

[Many of the foregoing particulars appeared in *Pastime* of June 12th last.—ED.]

William Ilbert Hancock.

THE subject of this notice was born at Wiveliscombe, and is now in the 23rd year of his age. He is one of a family of ten brothers, five of whom have gained renown on the football field, and two of whom have won distinction as international players. It is told of the Hancock family that they made by their exertions the local club one of the strongest in the county, and that they used to play the Rugby code constantly in a large garden. Doubtless this early training gave a stimulus to the natural tendency, and helped Bertie Hancock to gain the position he occupies to day. He was educated for a short time at Dulwich College, and entered Guy's in May, 1891. His first appearance in Inter-Hospital engagements was as one of the representatives of the Lawn Tennis Club. Already he had won many prizes in West Country tournaments, and about this time only suffered defeat in the final for the Somerset Challenge Cup. He speedily found his way into the Guy's six, and has played in every Cup tie for his Hospital from 1891–94 inclusive. He was captain of the Club in 1892 in which year the six repeated its victory of the previous year in winning the Inter-Hospital Lawn Tennis Cup; and it says much for the reputation Mr. Hancock has gained as a player in that he never lost a set in the singles of the Inter-Hospital matches. In 1892 his brother, Mr. E. D. ("Dubby") Hancock, who is also a Rugger "Blue," shared with him the honour of participation in the victory of his Hospital.

At cricket, Mr. W. I. Hancock has shown himself to be a bowler, a batsman, and a fieldsman of good repute. First playing for Guy's in the summer of 1892, he has appeared regularly for the Hospital since that date until the end of last season. He at first met with much success as a bowler, and obtained the Bowling Trophy with an average of 8·89 runs per wicket. As a bowler, he possesses medium pace with a break from the off and less frequently from the leg, and is at times almost unplayable. Latterly, he has improved wonderfully as a batsman, and has compiled several centuries for his Hospital. He has a decidedly free and clean style, is a rapid scorer, and when well set plays every kind of bowling with consummate ease and confidence. In 1892 he scored 454 runs—his highest 104, not out, with

(*From a photo by* THE LONDON STEREOSCOPIC COMPANY.)

an average of 28·37; and in 1894 he was most consistent, getting double figures in every innings but one, his highest being 110, and his average for the season 41·22. Mr. Hancock has appeared once for his county against Surrey at the Oval in 1893, and has been invited to play on other occasions, but has been unable to give the time up to the present. We hope he will soon become a regular member of the Eleven.

It is, however, at Rugby football that Bertie Hancock has shone most conspicuously, and but for the number of accidents with which it has been his misfortune to meet, there is no doubt that he would have received a trial ere now in the North and South match. Before coming to Guy's he played half-back for Wiveliscombe and Taunton, and at the time of his entry he got his cap for Somersetshire. He has played regularly—when not disabled—for Guy's during the past four seasons, and

was captain of the Club in the season of 1893–94. He was a most dangerous scorer as a half-back, and a difficult player to stop. At his best, at centre three-quarter he has certainly had no equal amongst any of the present Hospital teams, and very few among first-class players generally. Possessed of wonderful dodging powers, but running straight, he is able to gain a lot of ground for his side, and he is specially brilliant in attack. A sound and fearless tackler, and a safe kick with either foot, he has oftentimes saved his team when hard pressed, and should he escape accidents when playing for Richmond next season, we may assuredly hope that his sterling football qualities will soon gain for him International honours.

Mr. Hancock, a triple "Blue," a popular and true sportsman in the best sense of the word, has not neglected his Hospital work, as he has passed the primary Fellowship of the Royal College of Surgeons, a distinction which stamps as one of the best all-round men at Guy's.

Guy's Ladies' League.

A Meeting, at which Mrs. Randall Davidson presided, was held on June 28th, at the Treasurer's House, to consider a proposal to form an Association of Ladies in connection with Guy's Hospital, with the object of enabling its members to take an active interest in the social welfare of the patients.

Two objects were mentioned as forming a good basis on which the Association might begin its work. These were:—

1. To provide clothing for destitute patients on their discharge from the Hospital.

2. To arrange for ladies to visit the patients in the wards at times convenient to the authorities.

The meeting expressed general approval of the proposal, and appointed a committee to draw up draft rules and regulations for the Association, to be submitted to a future meeting, to be held in October. The committee is composed of the following ladies:—

Mrs. Randall Davidson.	Mrs. Pye-Smith.
Mrs. Fellowes.	The Matron.
Miss Hucks Gibbs.	Mrs. Bowden.
Mrs. Davies-Colley.	Mrs. Shaw, *Secretary*.

Vacant Appointments.

THERE is a vacancy in the Lectureship of Public Health, owing to the resignation of Dr. George Turner.

There is a vacancy for an Assistant Dental Surgeon and Demonstrator of Dental Microscopy, owing to the resignation of Mr. Mansbridge.

Applications for either of the above appointments should be sent to the Treasurer not later than July 20th.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G. F. H., BALHAM.—We must ask for further time to determine the reason of the remarkable condition of this urine, and, if possible, we should like to receive a further quantity. The viscosity is due neither to albumin nor mucin.

H. L. E. W., SALISBURY.—The growth consists solely of the fibro-muscular tissue of the uterus. It is a little œdematous in the middle. Has the piece been taken too far beyond the edge of the tumour?

G. P., RAMSEY.—The section of the tumour in the lip shows marked hypertrophy of the papillæ, and much inflammatory infiltration around the downgrowths of epithelium. There is no invasion of the muscle, but the appearances indicate an early stage of squamous-celled epithelioma of the lip.

W. E. A., WELLINGBORO'.—The tumour is a fibroma which becomes denser in structure on passing deeper into the tissues. There is nothing to indicate malignancy in the growth.

H. W., ST. JOHN'S COLLEGE PARK.—This specimen was so dry on arrival that its examination was unsatisfactory. However, there was no evidence of malignant disease, the substance of the growth being chiefly young connective tissue.

H. A. L., SWANSEA.—Tubercle bacilli are present in the sputum in considerable numbers.

S. H., CROMWELL ROAD, S.W.—No evidence of tuberculous disease of the kidney was seen, as neither tubercle bacilli nor pus could be found in the urine.

H. A. D., NEWTON ABBOT.—No tubercle bacilli could be found in the sediment of the urine after centrifugalizing.

PATHOLOGIST.

Appointments.

The following appointments have been made by the Treasurer:—

House-Physicians.—Mr. E. A. Peters (Dr. Taylor); Mr. H. A. Munro (Dr. Goodhart).

Assistant House-Physicians.—Messrs. J. H. Horton and A. A. H. Partridge.

House-Surgeons.—Messrs. F. J. Steward (Mr. Lucas) (for three months only); C. E. Carpmael (Mr. Golding-Bird).

Assistant House-Surgeons.—Messrs. S. Copley and C. H. Bryant.

Obstetric Residents.—Messrs. J. R. Steinhaeuser (July); M. A. Key (August); H. W. Collier (September).

Resident Medical Officer of Bright Ward.—Mr. L. A. Parry (commencing July 3rd).

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. G. L. Eastes, R. O. Moon, B. A. Richmond, W. W. Farnfield, A. V. Clarke, P. R. Lowe.

Dressers in the Eye Wards.—Messrs. R. H. Ashwin, C. D. Edwards (Mr. Higgens) (July); T. M. Thomas, A. P. Beddard (Mr. Brailey) (July); C. C. Stead, W. Tyson (Mr. Higgens) (September); A. G. Butler, L. C. Panting (Mr. Brailey) (September).

Surgeons' Dressers.—Messrs. E. Fisk, S. Whicher, A. H. Spicer, W. R. Davies, E. A. Prebble, R. Mathias (Mr. Howse); J. Howell, G. Burton-Brown, H. Alexander, W. J. Henson, W. E. Hills, H. E. Izard (Mr. Davies-Colley); H. T. S. Bell, N. H. Pike, C. H. Fagge, H. T. Hicks, W. E. Plummer, L. Worts (Mr. Lucas); W. R. Wood, W. T. Clarke, H. W. Dudgeon, S. G. Layman, C. E. S. Watson, R. T. Brown (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. H. Leader, B. B. Gough, E. I. Spriggs, A. B. Carter, W. Ramsden (Mr. Jacobson); A. W. Ormond, G. B. Pearson, W. N. East, R. P. Rowlands, C. P. Weekes (Mr. Symonds); F. S. Batchelor, F. J. Nicholls, W. H. M. Smith, H. J. Starling (Mr. Lane); C. C. Poole, S. H. Longhurst, A. E. B. Crosby, A. Kinsey-Morgan (Mr. Dunn).

Medical Ward Clerks.—Messrs. P. C. Higgins, F. C. Hitchins, R. B. Stamford, A. Earnshaw, A. J. Wernet, H. Bernard-Onraët, S. C. Clapham, E. F. Clowes, J. Dixon, Ed. Evans, E. C. Hort, J. T. Roberts, C. Jephcott, G. K. Levick, C. A. C. Askew, R. J. Rowland, J. O. Garland, C. R. Hodgson, A. E. Porter, M. H. Thornely, C. A. C. Salmon, E. J. O'Meara, A. M. Rygate, W. A. Fuller, D. L. Smith, R. S. Rowland, T. J. Vick, J. B. Walters, J. G. Watt, M. H. Way, C. C. Worts, J. M. Fortescue-Brickdale, W. C. Milward, J. B. A. Treusch, W. J. Lindsay, C. H. Mossop.

Assistant Physicians' Clerks.—Messrs. J. Moore, F. W. Lee, E. H. Pomeroy (Dr. Pitt); J. Ponsonby, H. Fulton, E. Moore (Dr. Shaw); C. J. Francis, A. T. Falwasser, H. R. Marsh (Dr. Washbourn).

Aural Surgeon's Dressers.—Messrs. F. J. H. Cann, C. C. Stead (July—August); W. A. Carden, P. E. Tresidder (September—October).

Dental Surgeons' Dressers.—Messrs. T. W. Stanton, (July and August); J. C. Constable (August and September); E. Coleman (September and October).

Dressers in the Throat Department.—Messrs. S. G. Graham, L. E. V. Every-Clayton, W. L. Stuart, F. W. Rowland, A. Salter, R. E. Delbruck, H. R. T. Fort, B. B. Ham.

Post-mortem Clerks.—Messrs. C. C. Jenkins, J. Robertson (July and August); H. J. Spon, T. L. Jackson, (August and September); C. T. Anderson, H. V. Smith (September and October).

Obstetric Ward Clerks.—Messrs. L. G. Reynolds, F. J. Lidderdale, D. Rice.

Obstetric Out-Patients' Clerks.—Messrs. C. J. Harnett, V. E. Collins, R. Howard (first half); P. E. Tresidder G. B. Muriel, A. S. J. Pearse (second half).

Surgical Ward Clerks.—Messrs. R. W. Mayston, A. C. Ambrose, E. Evans, R. T. Fitz-Hugh, J. E. Dupigny, F. J. H. Martin, W. Mussellwhite, J. E. H. Parsons, F. E. Fremantle, S. E. Denyer, H. W. Allan, A. R. Adams.

Assistant Surgeons' Clerks.—Messrs. R. P. Rowlands, W. Tyson (Mr. Jacobson); A. W. Ormond (Mr. Symonds); H. P. Ferraby (Mr. Lane); Mr. C. C. A. Pennington (Mr. Dunn).

Clerk in the Electrical Department.—Mr. R. Howard (July and August).

Clerk in the Skin Department.—Mr. F. J. Lidderdale.

Assistant Demonstrators of Anatomy.—Messrs. F. E. Walker, L. H. McGavin.

Dental Appointments.

The following Dental appointments have been recommended by the Dental Committee and approved by the Treasurer:—

Dental House-Surgeons.—Messrs. A. Cahill, C. A. H. Keall, E. Morgan.

Assistant Dental House-Surgeon.—Mr. N. Denham.

Demonstrators in the Conservation Room.—Messrs. L. Bidlake, G. G. Ellis, T. D. E. Goodman.

Dressers in the Gas Room.—Messrs. A. de Mierre, E. E. D. Heesom, W. J. M. Lacey, N. H. Oliver, N. Snell, B. G. Tasker.

Dressers in the Ordinary Extraction Room.—Messrs. E. C. Brown, C. N. Doyle, K. W. Goadby, G. Naish, A. E. Oddy, G. D. Slater.

Pass List.

University of Oxford, June, 1895.

Final Examination for the Degree of M.B., B.Ch.

Partridge, A. A. H., M.A.

Nursing News.

IT is with much regret that we have to record the retirement from our working ranks of three Sisters, viz.—the Night Sister (Miss Parrett), Sister Dorcas (Miss Earle), and Sister Stephen (Miss Howe).

This has made several changes necessary, and the following appointments are the result:—Sister Job (Miss Irwin) has been transferred to Stephen; Miss Pooley has been appointed Sister in Job ward; and Miss Cotton Sister in Dorcas ward. The Night Sister's post is being taken temporarily by Miss Bryant.

For some time now an alteration in the working of the surgery has been contemplated by the authorities, and on June 24th the duties were taken by a Sister (Miss Lawrence) with a probationer to assist her. It is hoped that greater efficiency in the working of this important department may result.

The Cricket Club Dinner.

ON Wednesday week a dinner was held in the Reading-room of the Club between the Past and Present Cricket Teams of the Hospital. Mr. Brailey presided, and, in all, the muster numbered some eight-and-twenty men. After the dinner the following toasts were proposed:—"The Guy's Cricket Club," by Mr. Brailey; "Our President," by Mr. Alexander; "Dr. Fawcett," by Mr. Layman; "Mr. Munro," by Mr. Brailey; "The Ladies," coupled with the name of Mr. E. T. Shorland, by Mr. Brailey. For the Cricket Club, Mr. Nicholls replied. The toasts of "The President" and "Dr. Fawcett" were received with great enthusiasm and with musical honours.

The President, in the course of a humorous speech, said that cricket commended itself to him for three things—first, the weaker side may gain the victory, or at least hold their own, as he believed had been the case that day; secondly, the devotee of the game appears to improve with time instead of falling off, so that the brilliant prospect was before each one of them of reaching that highest pinnacle of cricketing fame, the shilling testimonial. In the third place, cricket takes up a good deal of time, and is therefore a game which is specially adapted to the needs of the young practitioner with plenty of that commodity on his hands. He also alluded in fitting terms to the irreparable loss sustained by the club in the death of its president, Mr. Durham.

Mr. Francis being next called on for a speech, made some highly appropriate and very facetious remarks.

Mr. Shorland, replying for "The Ladies," disclaimed any special familiarity with his subject, and referred his hearers for information to Mr. Henry Rygate. It might be true that he was generally to the fore, as Mr. Brailey said, when any at all prepossessing young lady attended Ophthalmic Out-patients, but nevertheless he thought it very cruel of the President to betray him in that manner.

The evening closed with music, Mr. Layman and Mr. Fitz-Hugh both obliging with songs. "Auld Lang Syne" was rendered with enthusiasm by the company, which then separated.

Sport.

Cricket.

GUY'S HOSPITAL 1ST XI. v. MITCHAM.

Played at Honor Oak Park on June 22nd, and ended in a win for the visitors. Mitcham batted first on a perfect wicket, and put together 179, Clarke and Moorhouse playing freely for 31 and 45, not out respectively, and Winlaw getting 37 by useful though tedious cricket. Guy's, with plenty of time made but a sorry attempt against this score—by no means a formidable one considering the wicket. Clarke and Perks put on 50 for the first wicket, and after them, with the exception of Lavers, and at the end Crew and Featherstone, no one offered any resistance, and the innings closed for the miserable total of 92. Teams:—

MITCHAM.

G. P. K. Winlaw, b Clarke	1
W. W. Winlaw, b Harris	37
Hussey, run out	11
A. F. Clarke, c Hunter, b Harris	31
F. Hale, c Lavers, b Harris	9
T. P. Harvey, b Wetherell	4
F. Harris, c Hancock, b Harris	8
W. M. Moorhouse, not out	45
R. Pearson, b Clarke	5
J. Keene, c and b Clarke	0
R. Smith, b Clarke	3
Extras	25
Total	179

GUY'S.

First Innings.		Second Innings.	
A. Perks, c Clarke, b Keene	25	b Moorhouse	4
A. E. Clarke, c Clarke, b Keene	22	not out	46
W. Harris, b Hale	0	c Harris, b G. P. Winlaw	50
N. Lavers, b Hale	12	not out	1
F. C. Wetherell, b Keene	9		
E. D. Hancock, b Keene	0		
L. Humphry, lbw Keene	0		
E. J. Crew, b Hale	11		
E. G. Goddard, b Hale	0		
P. D. Hunter, b Hale	2		
F. R. Featherstone, not out	9		
Extras	2	Extras	11
Total	92	Total 2 wkts.	112

GUY'S 1ST XI. v. SURREY CLUB AND GROUND.

Played at the Oval on Monday, June 24th. Nicholls won the toss, and we went in. Clarke and Francis both unluckily put up rising balls in the slips, and two wickets fell for 13. Hancock lost his wicket just as he seemed well set, and soon afterwards Nicholls came in. Perks was caught at the wicket, having made 38. Nicholls, Alexander and Fitz-Hugh, all got runs, but the innings closed for 133. Though the Club and Ground got the runs, as was to be expected, with some ease, we were lucky on the wicket in dismissing them for their total. Henderson got 123 not out, a very patient innings, which was somewhat marred by two chances at the wicket before he reached his century. Hayes and Thompson made 30 and 25 respectively, both being run out, one by an excellent piece of fielding on the part of Goddard. It was very gratifying to hear from W. T. Graburn, that the Guy's fielding was the best he had seen on the Oval this year. Teams:—

GUY'S.

First Innings.		Second Innings.	
A. Perks, c Earl, b Hussey	38	b Hayes	24
A. E. Clarke, c Thompson, b Higgins	4	b Hayes	22
C. J. Francis, c Henderson, b Higgins	0		1
W. I. Hancock, c Earl, b Higgins	16		
F. J. Nicholls, c & b Higgins	17	not out	
K. B. Alexander, b Tregellas	21		
R. T. Fitz-Hugh, b Thompson	15	b Hayes	6
N. Lavers, run out	0	c Earl, b Keene	14
L. Humphry, c Tregellas, b Thompson	2	c Thompson, b Keene	13
E. G. Goddard, run out	5		
P. D. Hunter, not out	1		
Extras	14	Extras	12
Total	133	Total 5 wkts.	92

SURREY CLUB AND GROUND.

W. T. Graburn, b Clarke	11
Higgins, lbw, Hancock	7
Hayes, run out	30
Henderson, not out	123
R. Williams, c Fitz-Hugh, b Nicholls	1
Corden, b Francis	9
Thompson, run out	25
T. S. T. Tregellas, b Nicholls	18
Earl, b Clarke	5
Hussey, b Clarke	3
Keene, b Clarke	12
Extras	21
Total	265

PRESENT v. PAST.

This match, which had been postponed owing to the death of Mr. Durham, took place at Honor Oak on Wednesday, June 26th. A most pleasant game was the result, and we feel sure that everyone agrees with the suggestion of Dr. Fawcett, through whose energy this match came off, that it should be an annual affair, and looked upon as a general Guy's holiday. The Present were lucky in winning the toss, and, perhaps contrary to the expectations of either side, kept the Past in the field till four o'clock. The feature of the innings was Trouncer's 105, put together by the most excellent cricket, and unspoilt by a single chance; it included one 6 and fifteen 4's. Alexander made 72 by free cricket. Hancock got 34, and in one over punished his brother to the tune of four 4's. Fitz-Hugh had the bad luck to have his little finger broken, and we shall thus lose him in the Cup ties. Lavers and Hunter with 16 and 22 not out materially helped, both with their own runs and by staying with Trouncer. With the score at 296 Nicholls declared, and the Past entered on a somewhat hopeless task. In the end they got 190 for 7 wickets, leaving the game in favour of the Present. Scott, Hancock, Joyce and Busteed made 25, 25, 20 and 20 not out respectively, but the best innings was an excellent 79 not out of Francis. Teams:—

PRESENT.

A. Perks, b Joyce	16
A. E. Clarke, b Hancock	0
K. B. Alexander, b Hancock	72
F. J. Nicholls, run out	1
R. T. Fitz-Hugh, retired hurt	3
C. A. Trouncer, not out	105
E. D. Hancock, b Cruickshank	34
N. Lavers, b Shorland	16
P. D. Hunter, not out	22
F. Featherstone did not bat.	
E. G. Goddard did not bat.	
Extras	27
Total	296

PAST.

C. J. Francis, not out	79
W. J. Scott, b Goddard	25
W. I. Hancock, c Nicholls, b Clarke	25
E. T. Shorland, c & b Trouncer	2
R. B. Stamford, c Perks, b Trouncer	2
J. H. Joyce, c Goddard, b Trouncer	20
S. G. Layman, c Hunter, b Trouncer	2
N. H. Pike, c Goddard, b Trouncer	0
J. H. Busteed, not out	20
J. D. Cruickshank did not bat.	
H. B. Rygate did not bat.	
Extras	15
Total	190

GUY'S HOSPITAL 1ST XI. v. CHELMSFORD.

Played at Chelmsford on June 29th, and ended in a win for the Hospital, and Chelmsford's first defeat this year. The home side batted first and made 171, of which Mas contributed 63; the home umpire gave him a second innings when he had made 20, and, if possible, it was luckier than his first. Clarke took five wickets for 34, and Nicholls three for 32 with lobs. For Guy's,

Clarke got 27, and Alexander made a somewhat lucky 50, and with 120 for four wickets success seemed most probable, but Nicholls, after getting 25, was out to an excellent left-handed catch, and Lavers was caught and bowled by Lucas. Humphry and Crew, however, made a great stand and won the match, the former getting 48 and the latter 21. The innings ended for 218. Teams:—

CHELMSFORD.

R. C. Whittaker, c Lavers, b Hunter	28
H. H. Cobb, c Hunter, b Clarke	20
A. P. Lucas, c Lavers, b Clarke	3
J. H. Mas, c Clarke, b Nicholls	63
H. Gibson, lbw, b Goddard	15
G. F. Woods, c Nicholls, b Clarke	16
A. W. Newton, c Alexander, b Clarke	3
Rev. W. Bury, st Alexander, b Nicholls	1
J. D. Whittaker, c Alexander, b Clarke	4
J. Dixon, st Alexander, b Clarke	1
A. W. Smethurst, not out	6
Extras	11
Total	171

GUY'S.

A. Perks, c Woods, b Newton	1
A. E. Clarke, c & b Lucas	27
K. B. Alexander, c Woods, b Lucas	50
F. J. Nicholls, c Bury, b Lucas	25
N. Lavers, c & b Lucas	14
E. D. Hancock, c Cobb, b Newton	0
L. Humphry, b Newton	48
E. J. Crew, c Lucas, b Woods	21
P. D. Hunter, c Smethurst, b Woods	1
E. G. Goddard, b Woods	10
F. Featherstone, not out	5
Extras	16
Total	218

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

This is the only match to record for the 2nd XI. this time, and unfortunately it is the record of another defeat. Harrison's bowling proved altogether too much for our men. Palmer, however, hit about in grand style, and Cleveland's excellent stand very nearly saved us from actual defeat, but he was bowled in the last over of the match. For St. Thomas's, Atherton and Clarke played very good games, while Glasgow gave us an exhibition of the good old brickwall type. Teams:—

ST. THOMAS'S.

F. M. Bingham, b Palmer	2
A. E. Harrison, c Anderson, b Palmer	10
P. R. Browning, b Spriggs	16
W. Hodges, run out	2
A. Atherton, c Atkins, b Palmer	38
W. Thorman, b Palmer	6
H. Clarke, b Palmer	19
W. W. Jones, b Shorland	10
T. G. Glasgow, not out	16
S. D. Turner, b Shorland	10
C. Bourden, b Morgan	3
Extras	14
Total	146

GUY'S.

T. Morgan, b Harrison	13
E. I. Spriggs, b Bingham	10
E. T. Shorland, b Harrison	3
A. E. Cawston, b Harrison	10
W. G. Palmer, c Bingham, b Hodges	51
J. Biggs, b Harrison	2
J. Cleveland, b Hodges	14
J. De Coteau, b Harrison	3
C. T. Anderson, b Harrison	0
W. Thomas, b Harrison	4
J. Atkins, not out	0
Extras	13
Total	123

Guy's Hospital Rifle Association.

GUY'S v. ST. PAUL'S.

After scratching for the last two years we were at last able to raise a team to shoot against St. Paul's, and we journeyed to Bisley on Saturday, June 29th. As regards weather it is sufficient to say that it was "Bisley" weather, which conveys meaning enough to any man who has performed during the annual meeting. On arriving at 200 yards we found that four of their men had finished, but owing to there being some unoccupied targets all our team were soon able to shoot. The wind was most deceptive and required more allowance than seemed possible. For us Pearson was leading with 27, and Went for St. Paul's with 32. Their eighth man was not due till the afternoon when he added 17, making their total 204 to our 182. At 500 yards we appropriated some targets whose hirers had not arrived and finished before St. Paul's began. With the exception of Pearson's excellent 33, the whole team came to grief, only raising a total of 172, for which the wind was answerable. St. Paul's shot well, their captain doing best with 32, and made 192, aggregate 396, thus beating us by 42. Scores:

GUY'S.

	200	500	Agg'te.
J. Gardiner	19	25	44
A. Pearson	27	33	60
A. H. Bell	25	17	42
P. S. Mandy	17	17	34
G. G. Ellis	22	26	48
B. W. Moss	21	17	38
S. H. Mason	25	14	39
H. Fulham-Turner	26	23	49
			354

ST. PAUL'S.

	200	500	Agg'te.
Thompson	30	32	62
Arnett	26	29	55
Jamison	23	22	45
Bidwell	28	15	43
Went	32	23	55
Maurice	24	24	48
Blandford	24	21	45
Vaughan-Jones	17	26	43
			396

GUY'S v. WHITGIFT.

The return with Whitgift was shot at Marden Park on June 27th, but unfortunately with not the same result as on the former occasion. At 200 yards scoring was not brilliant, the highest being 28 from Fulham-Turner, and two men were distinctly off. As regards Scott-Turner, however, the woes of Extern are sufficient explanation, and Bell had to use his left eye, which is handicapping somewhat when shooting from the right shoulder. Whitgift, too, were off at 200, their highest scores being three 27's, and we went back to 500, leading by two points. There, however, a decided rot set in for our men, there being four scores under 20, and our total for this range was only 158, making an aggregate of 347. Scoring all through was bad, though Hampton put on 29 for Whitgift, but they had not such an evident tail, and totalled 174, aggregate 361, thus beating us by 14 points. Scores:—

GUY'S.

	200	500	Agg'te.
W. B. Secretan ...	26	17	43
P. S. Mandy	27	19	46
A. Scott-Turner ...	15	17	32
A. H. Bell	17	10	27
G. G. Ellis	24	23	47
B. W. Moss	26	22	48
A. Pearson	26	25	51
H. Fulham-Turner ...	28	25	53
			347

WHITGIFT.

	200	500	Agg'te.
D. Brodie	27	27	54
E. M. Simmins ...	20	24	44
R. S. Reid	27	19	46
C. E. Iredell	19	18	37
J. L. Hampton... ...	24	29	53
S. D. Roper	19	21	40
G. C. Hampton ...	27	17	44
E. Hinks	24	19	43
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PRIZE COMPETITION.

This much-talked-of competition took place at Ilford on Tuesday last, under meteorological conditions which might damp the ardour of the most ardent "pot-hunter." We commenced by sheltering for some minutes in a hut roofed with a sieve, while the rain descended the floods came and the winds blew. All day long the wind blew with an average velocity of about 25 miles an hour, with gusts of perhaps 30 miles an hour, sweeping across the range from left to right. This means an allowance of about 7 feet for wind at 600 yards, but when even this allowance is not a constant factor, and one has in addition occasional storms of rain that wash the paint off one's sights, to say nothing of frequent attacks of modesty on the part of the sun, whereby he was constrained to hide his head behind a cloud only to emerge when he was not wanted, the average man is wont to commune with himself and wonder whether, after all, insanity is rife in his family. We had a very fair muster of Guy's men; 18 in all came down and shot, while several who had promised were deterred by the weather.

Scoring, as a matter of course, was very low, only a few men pulling away from the crowd. At 200 yards, Fulham-Turner, who was first man down, made 27, which was in two cases equalled, but never beaten. At 500 yards, Pearson was unapproachable, the next score to his 30 at this range being three scores of 25, made by Jenkins, Bell, and Secretan. Both at this range and the next, Fulham-Turner went to pieces, although his average for this season is the highest in the Association. At 600 yards, Telling came to the front with 26, followed by Pearson and Ellis, each with 23. On the aggregates, Pearson led with 78—thus winning Dr. Pitt's Cup—followed by Telling with 70.

When the handicaps were added for the other prizes, the order became:—Telling (received 10 points) 80; Pearson (scratch) 78; Scott-Turner (15 points) 78; Holman (30 points) 78.

Cambridge University v. United Hospitals.

PRESSURE on our space compels us to leave over until next issue an account of this the second meeting of these Athletic Clubs, the first having been held in 1890, when the Hospital representatives journeyed to Cambridge and suffered easy defeat. The meeting under notice took place at Stamford Bridge, on Wednesday, the 26th June, and a strong and interesting programme of events was got through. On this occasion the Medicals placed three races to their credit, whilst they were only beaten by the narrowest possible margin in two of the other events.

Appointments.

FAGGE, Robert Hilton, M.R.C.S., L.R.C.P., has been appointed House-Physician to the Leicester Infirmary.

HAYWARD, John W., M.R.C.S., has been appointed Medical Officer for the Borough of Whitstable-on-Sea.

TODD, H. B., M.R.C.S., L.R.C.P., Lond., has been re-appointed Medical Officer of Health to the Charlton King's District Council.

SHILLITOE, Arthur, M.B., B.C., F.R.C.S., has been appointed Registrar to the Lock Hospital.

Birth.

WHITE.—On June 12th, at Harley Street, W., the wife of William Hale White, M.D., of a son.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, MEDICAL OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette.

JULY 20, 1895.

Fractures.

CLINICAL LECTURE BY MR. ARBUTHNOT LANE.

GENTLEMEN,—In previous clinical lectures I have often urged on you the importance of striving to obtain some definite knowledge of the causation of the several morbid conditions which are presented to you clinically, and having grasped clearly, to formulate in your mind the varying mechanical principles which should guide you in their treatment. Do not accept slavishly what we try to teach you, and regard the information supplied in the text-books with the keenest criticism.

The student too readily assumes that his teacher, from his age, experience and opportunities, is always in a better position to form an opinion than he is, but he forgets that we labour under a disadvantage from which he is fortunately exempt—namely, that while we have learnt most of our surgery, a mixture of a little science with an immense proportion of creed, he is learning it, and brings to bear on it the advantage of a more recent and better scientific education than we have had, and a mind free from surgical bias. Let him, therefore, assimilate no information unless it bears, marked indelibly on its face, the stamp of truth. We want more science in surgery and less of what is called experience or practice, which is but too often an ignorant repetition of the mistakes of our predecessors. Now that I have impressed on you the importance of regarding me and what I have to tell you from an attitude of criticism, and even scepticism, and accepting it only if you find it appeals to your common sense, and if you see that the application of the principles to the living patient during your studies in the wards confirms it, you must understand that after you have heard what I have got to say on the subject, you can form quite as good an opinion on its value as I can—probably a better one—since, as I said before, you start fresh, and with minds unsullied by the false impressions of years, and have no such bias as is inseparable from an interest in one's own productions. I believe that if you give the subject your careful consideration you will obtain some useful foundation on which you can base your treatment of fractures, and if I succeed in making you devote some thought to the subject I shall feel that my time has been very well spent, since, so far as I know, there is no department of surgery in which the same ignorance, conservatism and self-satisfaction on the part of the surgeon exists as in his knowledge and treatment of fractures.

I purpose devoting this hour to considering with you the various physical conditions which are presented by recent fractures of the long bones of the extremities in the living body.

Mechanics of the Extremities.—Let us first examine the structure of a limb, and for convenience sake let it be that of the lower extremity, since in it the physical conditions are somewhat more complicated than in the arm, as the weight of the body is transmitted through it. We find the long bones of the leg surrounded by a number of powerful muscles which are more fleshy and abundant in the upper two thirds of each than in the lower third. These exist in a state of tension, as is shown by the fact that section of a tendon, even under complete anæsthesia, is followed by some separation of the cut ends. This gaping is not limited only to tendons, for it occurs also when muscle fibres which run in the length of the limb are divided, as, for instance, the gluteus medius and minimus, and great difficulty may be experienced in bringing their sectional surfaces into accurate apposition by means of sutures.

The fasciæ, which in parts are very dense and strong, appear to be stretched to their utmost over the subjacent muscles along the length of the limb when it is placed in the extended position, and this is true also of the nerves, vessels and, to a lesser degree, of the skin. This last you can easily demonstrate by comparing the difficulty experienced in pinching up a piece of skin at right angles to the length of the limb with the relative ease with which it can be grasped in the direction of the long axis of the part.

Anyone who has witnessed a circular amputation through the centre of the thigh will have some practical experience of the degree of longitudinal tension in which the soft parts exist. Now, all those soft parts are ties in the length of the limb, and, as a whole, are absolutely incapable of extension.

These ties are not equally abundant, resistant and tense at all periods of life. For instance, the variations which exist between the conditions presented by the child, vigorous adult and feeble old person are very great indeed, and must be taken into practical consideration in determining the best mode of treatment suitable to a particular case.

In a dead body the surfaces of a fractured bone may usually be brought into accurate apposition by exercising traction on the fragments in a right direction.

If in a dead body you break the femur or the tibia and fibula by the exercise of sufficient violence to cause considerable displacement of the fragments, by exerting traction on the lower fragment in a suitable direction, it is usually possible to bring the broken surfaces into apposition.

The exception arises in such fractures of the fibula as result from forcible abduction of the foot, since, in these the overlapping of the broken surfaces of the bone is not always overcome by levering the foot forcibly inwards.

The factors that may oppose the accurate replacement of the fragments in the living body, namely, spasmodic contraction of the muscles, and hæmorrhage with inflammation.

In the living subject the restitution of the bone to its normal form may be opposed by the existence of involuntary contraction of the muscles acting in the length of the limb, which is set up by pain due to the movement of the fractured and damaged structures. By this means the ties of the bone which are formed by muscles, are shortened.

How far this involuntary contraction opposes replacement can be determined accurately in any particular case by placing the patient under an anæsthetic, when it ceases to exist. That surgeons have laid a great deal of stress upon the importance of this factor in producing deformity you will readily gather from an examination of works on fractures. Personally, as the result of experiment, I should say that it is a factor of no practical importance whatever. If the part is fixed, or if some traction is exerted on it for some time, it is readily overcome. Still, I would advise you to measure the degree in which it is capable of producing deformity in such fractures as you have an opportunity of examining before and during the administration of an anæsthetic. If you wish to obtain further information of the manner in which the several muscles are supposed to act in producing deformity, you will find the subject fully described and illustrated in some of your anatomical and surgical text-books.

Now I will pass on to the consideration of the factor which is in my opinion of the greatest importance in opposing restitution, should it be present to any extent. I refer to such hæmorrhage into the soft parts about the fragments, which very frequently follows upon a fracture, and to the inflammatory process which ensues at a still later stage.

Whether any hæmorrhage takes place at all, and the duration of the interval between the onset of the hæmorrhage and the time when the injury was sustained, must depend largely on the strength of the bone, the amount and character of the force which broke it, the bulk of soft parts about the fracture and the damage of vessels of some size. You can readily understand that in a badly nourished child, or in a feeble old subject, a bone may yield under the influence of very little force, and practically no hæmorrhage whatever may result.

Again, in a fracture the amount of hæmorrhage may be exceedingly small, in fact so little as to give no clinical manifestation of its presence. Yet after an interval of time a considerable amount of inflammation and thickening of the soft parts or ties may arise, producing resistance to the replacement of fragments. Or many hours may elapse before blood is poured out in sufficient quantity into the ties to oppose replacement of fragments. In some cases, as in fractures through the centre of the femur in the vigorous adult, the circumference of the thigh in the position of the fracture may increase considerably within a few minutes of the receipt of the injury. As a rule you may calculate on the amount of hæmorrhage and its rate of onset together with that of the inflammatory symptoms varying directly with the muscularity of the part affected.

I need hardly point out that the amount of blood effused is encouraged by the overlapping of the fragments produced by the injury; since the torn vessels are by this means relieved of the pressure normally exerted on them by the soft parts in their natural degree of tension, and the amount of pressure requisite to stop bleeding is not reached for a considerable time on account of the relaxation of the ties, resulting from the foreshortening of the bony framework which they envelope.

You will recognise that in hæmorrhage resulting from fracture as in hæmorrhage from other causes, its amount will be largely influenced by the exercise of pressure artificially applied, or by the abundant use of ice.

Should the fracture be observed before any marked hæmorrhage has resulted, it is obvious that by suitable traction and by complete fixation, assisted by sufficient local pressure, any further extravasation of blood may be avoided. If hæmorrhage has already taken place, the shortening of the ties in the length of the limb will exist so long as the soft parts are swollen by blood, or by the inflammatory exudation which succeeds it. Till these materials have been absorbed the ties cannot be restored to their normal length, nor can the broken surfaces be brought into their anatomical relationship to one another. The duration of this period varies between a few days to a few weeks.

Unless sufficient tension is exerted constantly upon the altered ties during the period in which absorption is taking place the ties may remain shortened, and subsequent extension will be of but little service in restoring them to their original length, and a permanent alteration in the form of the broken bone must exist.

The lower fragment must be retained so that its axis corresponds exactly or as near as possible to that of the upper.

You would hardly imagine that it is requisite for me to lay stress on the imperative necessity of keeping the lower fragment in such a position that its broken surface can be brought immediately or after the shortening of the ties has been completely overcome into continuity with that of the upper.

If in the dead body in which a fracture of the tibia and fibula has been produced by violence, sufficient to allow of fairly free mobility of the fragments on each other, the lower fragments be rotated around an axis to a degree not corresponding with that occupied by the upper fragments, an amount of overlapping of the bones must occur directly proportional to the variation due to the resistance offered by the unyielding ties in the length of the bones. This overlapping would, in the living body, be increased possibly by spasmodic contraction should it exist, and very considerably by hæmorrhage and inflammatory effusion should it take place in any quantity in the soft parts in and about the fracture.

In a paper read at the meeting of the British Medical Association in 1893, entitled "The Fallacy of the Vertical Foot-piece," I pointed out the fact that when the subject is lying at rest, in the supine position, the weight of the lower extremity, and especially of its relatively much more weighty upper segment, bears such a relation to the hip-joint that the whole of the lower limb rotates outwards around an axis corresponding to its length to a degree that varies within limits which are influenced by the age and muscular development of the individual. For instance, in a man who habitually carries two or three hundred-weight on his back, the amount of rotation is not nearly so great as it is in the case of a man following some sedentary occupation. This rotation is limited almost entirely by the resistance offered by the capsular ligament of the joint, and increases slightly, but not definitely, after several days of continued recumbency in this position.

Now, it is a curious thing that surgeons do not ever seem to have recognised this fact, for in treating solutions of continuity of the lower extremity they have always made every effort in their power to retain the foot in such a position that when the patient lies in the supine posture the foot is placed vertically, or, to be more accurate, the foot is retained in such a position upon the foot-piece that its inner margin forms with the vertical an angle open backwards. If the solution of continuity is very complete, and the fracture an oblique one, the axis of the upper fragment would be indicated by the foot so placed that its inner margin forms with the vertical an angle of about 45° open forwards, while the lower fragment forms with the vertical an angle of five or more degrees open backwards.

In the case of a single bone like the femur, this means a considerable overlapping of fragments, while, in the case of the tibia and fibula, an interlocking of fragments also takes place. In spite of this demonstration of the tendency for harm, and the utter want of principle involved in the application of the vertical foot-piece, one still sees it used by many surgeons as it has been used for many hundreds of years. There is certainly no science in the use of the vertical foot-piece, which now remains only as a vestige of an exploded creed.

The disadvantages which result from union of the fragments in an imperfect position, and the manner in which the results are influenced by the age, occupation, and surroundings of the patient.

We will consider in order the various changes in the skeleton that may ensue in consequence of a fracture of one or more long bones; the unequal degree in which these changes take place in the upper and lower extremities; and the factors determining their development and their clinical symptoms. I would remind you that the normal form of our bones and joints exists only as long as we lead a normal existence, combining various movements of activity with attitudes of rest. You are aware that if the growing subject is confined to attitudes of rest, avoiding movements of activity, deformities arise, which are due chiefly to changes in the joints and ends of the bones, as, for example, knock-knee; and again, if one movement, or sequence of movements, of activity is assumed habitually, and other attitudes of activity with those of rest avoided, a deformity characteristic of the attitude of activity is developed, a deviation from the normal arising in consequence, being also due chiefly to changes in the articulations and in the ends of the bones.*

Obviously, then, our anatomy remains normal only as long as our mechanical relationship to our surroundings continues so, and any variation in the mechanical relationship is followed by definite physical changes in the bones and joints.

In other words, the problem of evolution is purely a mechanical one, and its proof is telescoped into the life-time of a labourer or into that of a child suffering from one of the resting deformities. These are the experiments that nature makes for us, and by their consideration we become able to understand larger problems.

I think you will now agree with me that the form and structure of a joint remains normal only so long as the mode of transmission of force through it remains normal; alter these lines of force transmission in any way, and changes in structure proportional in degree must arise.

When the direction and mode of transmission of force through one or more joints of a single limb is altered by the fracture of a long bone, whose fragments unite in such a manner that the axis of the one corresponds no longer with that of the other, and as the angle formed by these axes with one another is often great, or if parallel, as they are frequently separated by a considerable interval, owing to overlapping of fragments, the mechanics of the joints formed by the ends of these bones, as of others influenced by the alteration in the lines of force, are changed in a definite and measurable degree from the normal.

* "A Clinical Lecture on Acquired Deformities," *Clinical Journal*, January 30th, 1895.

As already indicated, it is obvious that the joints of the lower extremity offer us a much better field than those of the upper in which to study these changes, for the reason that the weight of the body is habitually transmitted through the former, and in consequence the changes which develope in them must be very much exaggerated as compared with those which arise in the latter. Therefore we will proceed to examine the conditions of the joints of the lower extremity which result from fracture, and we will find that they may, for convenience sake, be divided into two distinct groups, though there is, of course, no sharp definition in the character of the changes. The very important factor which determines this variation in the results of pressure is the "age" of the individual, and its influence is one that must, as you will see, affect very materially the character of our treatment of fractures.

In the comparatively young adult considerable deformity, with the consequent alterations in the physiology or functions of the joints influenced, bring about changes which are, perhaps, best described by the term "adaptive." By this is meant necessary changes in the form, and, perhaps, in the planes of the articular surfaces without the articular cartilage being other than absolutely normal, together with a corresponding alteration in the limits of attachment of the ligaments and synovial membrane, both of which are normal in structure and function, while the secretion of the latter is not excessive in amount.

After a certain period of life, which varies within wide limits with the habits, occupation, and surroundings of the individual, but which may be roughly averaged as about 40 years, this being probably much too high an estimate for labouring people, an altogether different series of changes takes place. These I have called "passive," for want of a better and more descriptive term. They consist in the removal of the articular cartilage at such places where the altered physiology of the joint causes the transmission of an amount of pressure which is abnormally great as compared to that which the same surfaces transmitted previous to the injury. After the cartilage is destroyed, the same factor, associated with unaccustomed friction, produces sclerosing, eburnation, and gradual removal of the opposing exposed surfaces of bone. The area and form of the articular surfaces are also modified by deposition of cartilage and bone on the margins, the synovial membrane becomes more bulky and developes abnormal fringes, and the synovial fluid is secreted in a quantity often largely in excess of what is normally sufficient. The ligaments may have their attachments displaced and their functions very materially altered, owing, to some extent, to changes in the axis around which rotation takes place. All these changes used to be regarded by the pathologist as indicative of the presence of a disease which was known by names such as rheumatoid arthritis, osteo-arthritis, rheumatic gout, etc.; and he would be a daring student who at an examination-table would designate these changes as being other than due to this disease. Perhaps the best term to apply to them was one for which I am responsible,* namely, "mechanical or traumatic arthritis," remembering, however, that these changes resulting from fracture form but a small group of that very comprehensive class.

As to the clinical manifestations of these conditions, the "adaptive" changes are frequently unassociated with any pain or discomfort, except, perhaps, for a short time after the patient begins to get about, but the "passive" changes are on a very different footing. Their presence means that in their slighter degrees of development the patient experiences a feeling of insecurity in, or imperfect control over the movements of the part, and in their most marked forms a degree of pain that sooner or later absolutely incapacitates the sufferer from transmitting the weight of the body through the joints of the leg for any useful purpose.

Nor is this the only trouble. Should the patient be affected with true rheumatoid arthritis, or with rheumatism, the chances are that the damaged joint or joints will be first attacked, or be more severely affected than others. Again, as all movements in the joints cause pain or discomfort, the patient uses the muscles of the limb in a very partial manner, retaining part or the whole of the limb more or less completely rigid. As a result of this, the foot, and later, the leg, become œdematous, and organisms readily establish themselves on such areas of the skin where the vitality of the tissues is most depreciated, and eczema, and later ulceration develope.

Evidence as to results of present modes of treatment.—Concerning the evidence I would point out that of 40 cases of fracture of the tibia and fibula collected by Mr. F. J. Steward, he found 19, or 48 per cent., suffered financially owing either to inability to follow their former occupation, or to earn as much as was earned at their original occupation; 15, or 38 per cent., suffered pain at the seat of injury; and six, or 15 per cent., had pain in the ankle, and four of them had pain in the knee-joint; 12, or 30 per cent., suffered from insecurity of the limb, in nearly every case this insecurity being referred to the vicinity of the subastragaloid and ankle-joints. In several of the cases these troubles did not arise till a period varying from one to ten years after the injury. In 23 cases of similar fractures in men following occupations which necessitated heavy work and lifting of weights, 13, or 56 per cent., suffered financially owing to inability to do such heavy work; 12, or 52 per cent., had pain either at the seat of fracture or in the joints of the knee or ankle, or in both; and nine, or 39 per cent., suffered from more or less insecurity in the whole limb.

The following 16 cases of fracture of the shaft of the femur, and 13 cases of Pott's fracture, collected by Mr. Beddoe, with the very active assistance of Messrs. Roberts and Clapham, will give you a very good idea of the results which are usually obtained by hospital treatment.

* "Chronic Traumatic Arthritis," *Lancet*, January 30th, 1892.

TABLE I.—*Pott's Fractures.*

No.	Occupation.	Age.	Date of Fracture.	Time in Hospital.	Present Condition.	Condition as regards Work.
1	Carman ...	30	1893	14 days	Depression at seat of fracture... ...	Ankle was very weak for some time; still has pain after a hard day's work.
2	Labourer ...	32	1893	14 days	Distinct depression 1½in. above external malleolus, the displacement of fragments not having been reduced.	Has continual pain in ankle and subastragaloid joints; impossible to do anything but the lightest work, and that with considerable pain.
3	Bricklayer's labourer	49	1893	A few days	Slight depression at seat of fracture; some eversion still.	Quite unable to do any work for five months; has been able to do but very little since from pain in ankle and subastragaloid joints.
4	Accountant ...	58	1893	6 days	Depression at seat of fracture... ...	Unable to walk any distance from pain in ankle and subastragaloid joints.
5	Stickmaker ...	64	1893	14 days	No displacement, but a little thickening of bone at seat of fracture.	Has pain on standing for some time.
6	Labourer ...	53	1891	A month	Movement at ankle-joint somewhat limited.	Returned to work in two months; has suffered much pain at intervals; ankle still feels very weak.
7	Leatherdresser	27	1891	3 days	Slight depression at seat of fracture	Patient does his work, but suffers great inconvenience when standing for long.
8	Dock labourer	35	1893	A few days	No displacement	Pain on change of weather only.
9	Labourer ...	31	1891	2 days	——	Can work as well as ever; very occasional pain only.
10	Waterside labourer	32	1892	5 days	Slight displacement; no deformity ...	Has not been able to do much work since on account of pain in ankle.
11	Constable ...	29	1893	A few days	——	Can do his work all right; has occasional pain only.
12	Porter	38	March, 1894	7 days	A slight rim at seat of fracture ...	Has a good deal of pain in his foot occasionally, and is able to follow his employment, but with some discomfort.
13	Engine-man ...	48	Feb., 1894	A few days	No displacement	Can now work as well as before, but he had a good deal of pain for some months after the accident.

TABLE II.—*Fractured Shaft of the Femur.*

No.	Occupation.	Age.*	Date of Fracture.	Seat of Fracture.	Time in Hospital.	Condition on Discharge.	Present Condition.	Capacity for Work.
1	Labourer...	50	June, 1892	Junction of middle and lower thirds	6 weeks	Satisfactory; ½in. short	Pain and weakness at seat of fracture; pain and stiffness in knee; no obvious deformity.	Is unable to follow his regular employment; can do odd jobs only; earns but very little.
2	Carman ...	36	June, 1890	Middle third	11 weeks	Apparently satisfactory	Lame; pain in knee and hip; knee swells after walking; bowing of femur.	Cannot work nearly so well as before accident; was nine months before he could do any work at all.
3	Boot-welter	43	1892	Middle and upper thirds	7 weeks	Apparently satisfactory	Lame; pain in thigh.	Cannot do his work so well; was eighteen months before he could work, and then could not stand for any length of time.
4	Labourer...	58	1890	Fracture in two places	4 months	2in. short	Pain and weakness in limb at seat of fracture and in knee-joint.	Has done no work since.
5	Riverside labourer	40	1893	Upper and middle thirds	6 weeks	⅞in. short	Lame; occasional pain in thigh.	Is not able to work nearly so well as before; his wage-earning power has much diminished; was six months before he could work at all.
6	Fitter's labourer	55	1893	Upper third	7 weeks	Some little deformity	Lame; pain and insecurity in limb; limb occasionally helpless, bowing outwards.	Is not able to work nearly so well as before; was four months before he did anything.
7	Blacksmith	40	1894	Above centre	9 weeks	—	2½in. short; increasing pain in knee and hip; can only hobble with a stick.	Unable to follow any employment.
8	Porter ...	38	1890	Upper third	—	—	1½in. short; pain in the thigh, discomfort in knee and hip; cannot bear his weight upon his leg.	Unable to follow any occupation.
9	Engine-driver	56	1893	Lower third	6 weeks	1in. short; adhesion in knee broken down in three months	No deformity; slight pain in ankle on exertion; foot rotated inwards slightly.	Can perform heavy work, but is out of employment consequent upon his being incapacitated for seven months.
10	Labourer...	32	1892	Lower third	6 weeks	½in. short	No pain; not lame; foot turns out a little.	Can work well.
11	Carman ...	39	1892	Middle and upper thirds	7 weeks	1in. short	No pain; limps a little.	—
12	Drayman...	47	1890	Lower and middle thirds	8 weeks	1½in. short	Good firm limb, but cannot flex knee to full extent.	Can work satisfactorily, but cannot carry weight uphill; could not work for six months.
13	Carman ..	37	1889	Lower and middle thirds	6 weeks	½in. short	No lameness and no deformity.	Can do his work as well as before.
14	Labourer..	29	1891	Middle third	6 weeks	½in. short	No lameness and no deformity.	Can work well, but could not for nineteen weeks.
15	Watchman	42	1890	Middle third	7 weeks	—	No lameness, no deformity, and no pain.	Can work well, but was unable to for three months.
16	Drayman...	49	1893	Upper and middle thirds	9 weeks	⅞in. short	No lameness, no deformity, and no pain.	Can work as well as before.

* Age refers to age at time of fracture.

Now, these results refer to hospital patients who are usually strong, vigorous men with bones requiring the exercise of a considerable amount of force to break them. Therefore, they represent probably very much worse results than one would expect to find in the mixed cases of general practice.

Principles which should guide us in the treatment of fractures.—One thing I think we have learnt is, that in fractures of the long bones of the lower extremity especially, no uniform plan of treatment can be adopted, as the conditions we have to meet are so variable. For instance, in fractures of the tibia and fibula seen before sufficient hæmorrhage has ensued to oppose the accurate replacement of the fragments with or without an anæsthetic, or in cases when, owing to a very fragile condition of bone, no hæmorrhage results, some form of rigid casing applied, in the former condition without delay, would be of excellent service, since the pressure exerted by the apparatus is usually sufficient to prevent any further escape of blood from the vessels.

In the case of fracture of these bones in the vigorous male subject produced by considerable violence and associated with much bruising and extravasation, as we so often see them in the wards of our large general hospitals, the mechanical conditions which already exist absolutely oppose restitution of the fragments in accurate apposition. To apply a rigid apparatus under these circumstances would simply ensure the union of the bones in a bad position with the mechanical and financial depreciation, and other serious disadvantages which will inevitably result if the patient has reached middle life.

Should the sufferer be engaged in a sedentary occupation, as that of a tailor, shoemaker, etc., he will probably earn as much after as before the injury, and will be liable to the other disadvantages which I have indicated in a lesser degree.

But if the patient is a coal-heaver, fireman, sailor, or even a waiter, his future must of necessity be more or less disastrous.

In some of these cases, if the seat of fracture and the degree of swelling permit it, it is sometimes possible by the judicious application of traction upon the lower fragment to bring the broken surfaces with accurate apposition after the inflammatory material has been absorbed. Mr. Beddoe, with ready ingenuity, suggested the use of an old boot in order to distribute the pressure of the extension apparatus uniformly.

Should the circumstances be such that any prospect of obtaining the reconstitution of the bone or bones in their original form seems improbable, I would advise you to expose the fragments, and by forcible traction and by mechanical leverage and approximation unite the fragments with steel screws, just as you would the broken leg of a chair or table. I have been very severely criticised for urging on the profession the adoption of more perfect surgical methods than those they have had in use, practically unchanged, since surgery existed. Mr. Marmaduke Shield took as his text my final remark in a lecture of mine published in the *Clinical Journal*, April 17th, 1895, for a paper published in the same periodical of May 15th, 1895. That remark was that "the treatment of fractures as it exists at present is a disgrace to surgical practice." He treats the subject in his usual masterly manner, and I would urge you to read it carefully. Still, in spite of his kindly criticism, I will not depart one jot from my statement, except in the face of definite evidence to the contrary, with which no one has yet ventured to supply us. I cannot agree that because some surgeons may not feel justified in accepting the risks of an operation requiring a moderate amount of skill, and only such cleanliness as is requisite for the safe performance of any surgical operation, that we should follow in fractures a principle of treatment that varies from that adopted in other branches of surgery. It seems to me that instead of accepting a second-rate surgery, those who come across and treat these cases all over the country should render themselves more efficient as surgeons than it is assumed they now are.

Gentlemen, I do not wish you to go away with the idea that in every case of fracture of the long bones of the limbs in which you cannot place the fragments in accurate apposition, occurring in a subject dependent for his livelihood on the more or less perfect usefulness of that limb, or in one in whom symmetry of form is a matter of the greatest importance, you are to expose the fragments and to unite them with steel screws or wire any more than you should perform any other important surgical operation, unless you are confident, not only of your ability to do the operation skilfully, but also of the absolute cleanliness of yourself and your assistants, and that the surroundings of the patient as regards nursing, hygiene, etc., are such as would justify you in accepting what must always be a terrible responsibility, since failure in any of your precautions may entail on the patient loss of life or limb. If after careful consideration you are of opinion that an operation is the best course to pursue, and you are convinced that you are justified in accepting the risk of its performance, you should inform the patient fully of the various results which are likely to ensue from mechanical arrangements and from operative measures, so that he may be in a position to decide as to what choice he will make. I think you will find that in proportion as the surgeon requires confidence in the safety of his operative procedures, begotten of a thorough knowledge and careful application of the principles of aseptic surgery, so you will see him interfering actively with increasing frequency in the treatment of simple fractures of all kinds, and the various methods by which it is attempted to reconstitute fractured bones, especially of the lower extremity, in their original form by means of splints, will, in a considerable proportion of cases, fall into disuse.

The limits of the time I have at my disposal render it impossible for me to discuss the subject of the treatment of the various forms of fractures as one would wish, since it would require one to spend very many hours on the subject. I will, however, be satisfied if I have

helped you to grasp the varying physical conditions you have got to meet, and, consequently, the mechanical principles that should guide you in their treatment, and I will leave the consideration of the application of these principles in any particular case to your good sense and judgment.

Hospital News.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

ACCIDENT	3.	Fractured patella.
	5.	Punctured wound of posterior tibial artery behind internal malleolus. Fractured tibia.
	14.	Compound fracture tibia and fibula. Amputation.
	15.	Fractured femur.
NAAMAN	15.	Epithelioma of lip.
	17.	Congenital funicular inguinal hernia, strangulated on its first descent. Kelotomy.
CHARITY	6.	Rachitis. Bowed tibiæ.
	8.	Rachitis. Bowed femora and tibiæ. Genu valgum.
	10.	Gunshot wound.

CASES UNDER MR. DAVIES-COLLEY.

CORNELIUS	2, 4, 19.	Fractured tibia and fibula.
	4.	Compound fracture tibia and fibula.
	12.	Fractured pelvis. Ruptured urethra.
LYDIA	1.	Retro-peritoneal hydatid cyst in right lumbar region. Simulating kidney tumour. Incision and removal of hydatid cyst.
	5.	Fracture through head of fibula.
	18.	Reducible inguinal hernia.
	20.	Osteitis of upper extremity of fibula following sprain of knee.
	22.	Periostitis of tibia during convalesence from typhoid.
	25.	Recurrent synovitis of knee-joint in child of six. Considerable distension of synovial membrane.
LUKE	6.	Irreducible acquired inguinal hernia.
	9.	Old reducible inguinal hernia on right side. Irreducible femoral hernia on left side.
	11.	Chronic suppurative arthritis of knee-joint. Amputation through thigh.
	19.	Polypus of rectum.

CASES UNDER MR. LUCAS.

LYDIA	12.	Varicose veins.
	16.	Moveable kidney.
	Cot.	Umbilical hernia.
JOB	16.	Mastoid abscess.
	18.	Necrosis of upper jaw.

CASES UNDER MR. GOLDING-BIRD.

MARTHA	1, 20.	Tubercular glands in neck.
	4.	Anal ulcer.
	5.	Umbilical hernia. Radical cure.
	6.	Strangulated femoral hernia. Kelotomy. Carcinoma recti.
	8.	Hare lip. Cheiloplasty.
	21.	Mastoid abscess. Antrectomy.
LAZARUS	7.	Congenital talipes equino-varus.
	8.	Deflected septum nasi.
	11.	Malignant stricture of œsophagus. Gastrostomy.
	13.	Tubercular teno-synovitis.
	15.	Tubercular bursitis (bursa over great trochanter). Excision of bursa.

CASES UNDER MR. LANE.

JOB	12.	? Growth in bowel, or ulcerative colitis.
	13.	Gonorrhœal cystitis and prostatitis.
	14.	Growth in rectum.

The Arthur Durham Memorial.

IT is proposed to raise a fund of £2,000 to endow in perpetuity Two Beds in memory of the late Mr. Arthur E. Durham. The Committee gratefully acknowledge the following third list of subscriptions, but much regret that the hopes expressed in the last issue have fallen so far short of fulfilment.

	£	s.	d.
Amount previously acknowledged ...	1,234	12	6
Frank, P., Esq., M.D., Cannes, per Dr. Pye-Smith	10	10	0
Clague, J., Esq., Isle of Man	5	5	0
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Walker, F. E., Esq., Guy's	0	10	6
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Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

From "Darkest Africa."

DEAR SIR,—This letter, if it reaches you, ought to be a precious one, so please don't throw it into the waste-paper basket (where, alas, all my other communications with editors have lodged) but put it into the GAZETTE. For all nature wars against the mails. Half-starved lions scare the armed Makua (not a gunboat but blacks from Mozambique), and their propensity for inwardly digesting, since they cannot read or learn epistolary matter, would have cheered the heart of the author of the Pauline epistles.

I feel I should disappoint the readers of the GAZETTE were I to avoid medical topics altogether. Therefore I cast the following case at you. A planter, æt. 25, had been in the country eighteen months, and of course had had several attacks of malaria. For the last four months he felt out of sorts, and a fortnight ago, whilst walking, he suddenly felt his legs give way, and fell.

Since then he has been in bed, unable to walk, in fact hardly able to raise his legs; has vomited from time to time and has felt wretchedly weak. I saw him for the first time a few days ago, and diagnosed peripheral neuritis following malaria. But there were many peculiar points about the case, for though there were the ordinary symptoms of loss of motor power, wasting of muscles, tenderness on pinching the muscles, tenderness over nerve-trunks in his legs and forearm, and loss of reflexes, yet there were no anæsthesia, no tinglings, cramps, or numbness. There was the daily vomiting and a pulse which continuously beat at the rate of 120, and was an alarming pulse. It seemed as though his vagus was implicated. I began to think of beri-beri, and read it up, but the symptoms did not fit in somehow. To-day the message came that he was worse. I found him dying, his heart failing rapidly. No stimulus—and I tried all I knew—produced any permanent effect. Two veins in his arm and an external jugular were opened, but only a few ounces of blood came away. One of the men at the death-bed, an old inhabitant, remarked that he was very quick at dying. I asked him how many deaths he had seen—he said eighteen. A death of this sort creates a kind of panic amongst the whites; they all think, "when will my turn come." There is an extraordinary mixture of the comic, beautiful, and the tragic in this country. Whilst coming up the river I shot some duck. The black boys at once rushed into the water to get them. A punting pole was unshipped and floated down stream; one of the boys swam after it about 380 yards and then disappeared into some rushes. We were waiting for him, when suddenly we heard a loud cry, followed by other cries of distress, "Mother, mother, come quickly." The boys looked aghast and said, "crocodile." We ran through the water and reeds to where the cries came from, but before we could get there the cries had ceased, and on arriving we found no traces of the boy. One of the niggers said he saw a crocodile get the poor fellow by the legs. The boy struggled and caught hold of the reeds, but the brute pulled him further under water and then took him by the waist and drew him out of sight.

Yet, covering all the tragedy of deaths by fever, by wild beasts, by the poison ordeal, there is a smiling surface. The natives seem always in good spirits, and their woes don't have any lasting effect on them. The country is most lovely. From my window I look across a plain covered with low trees, teeming with game, broken here and there by a granite hill, on to a magnificent mass of granite mountain 10,000 feet high. It hardly seems like tropical Africa, but nevertheless it is true that the houses here are built with fireplaces, for it is quite cold at night time, and on the top of Mount Zomba there is a delicious climate, which reminds one of England. The journey out gradually accustoms one to the surroundings, but if a G. P. were suddenly transported here he would be astounded at the manner of carrying on practice. For instance, I went the other day to see some sick Sikhs at an outlying fort. The path was partly on the hill and partly over the plain. On the former the track was strewn with granite, and in the latter one had to plough a way through grass high above the head. We travel in hammocks slung from a pole carried by two men. To get along quickly there should be ten or twelve carriers. Behind these are about ten more carrying your bed, bedding, pots and pans, food, water, gun and rifle. You shoot guinea-fowl and pigeons as you go along, and when the hunting season is on—that is when the bush fires have burnt down the tall grass—any sort of game, from a lion to a hog, may cross your path. When night comes on, dropping down like a curtain, for there is scarcely any twilight, you put up in the nearest village, to pursue your journey the next morning.

My work at Zomba consists in looking after the Europeans when they get fever, and trying to assure them that they are not going to die, in dressing the sores of the Sikhs, and doctoring about two hundred natives. The native is a most amusing patient: he comes up with his hand on his head or stomach, or pointing to a sore on his foot caused by a burrowing flea. Stiff doses of castor oil rid him of the first two; but the flea makes great havoc of his feet, and sometimes the toes become gangrenous. With him medicine is almost a god, and is hopelessly mixed up with witchcraft. When the white man does anything which to him would be impossible, the native does not credit him with pluck or daring, but consoles himself for his defeat by saying the white man had better medicine on his person. In a few months there will be some more fighting, for there are several chiefs in strong positions on the mountains, who have continued to steal and plunder and deal in slaves.

Three GAZETTES have reached me since I have been here, and it is a significant fact that I find myself turning to "Passim" before absorbing the "Scientific Diagnosis of Nervous Disease."—I remain, etc.,

Zomba. WORDSWORTH POOLE.

School Notices.

Applications are invited for the post of Assistant Demonstrator in Physiology, and should be sent to the Medical School Office not later than Saturday, July 27th. Particulars as to duties and remuneration may be learnt from the Demonstrators in Physiology.

Applications are invited for the post of Assistant Demonstrator of Biology, and should be sent to the Medical School Office not later than Thursday, July 25th. Particulars of duties and remuneration may be obtained of the Dean.

It is proposed to appoint a Senior Student to assist the Surgical Registrar in the examination of pathological specimens. Particulars as to duties and remuneration may be learnt from Mr. G. B. Smith. Applications should be made to the Dean, not later than Saturday, July 27th. L. E. SHAW, *Dean.*

Dr. George Turner.

ON Saturday last a complimentary dinner was given to Dr. George Turner, at Limmer's Hotel, Dr. Pye-Smith being in the chair. In addition to the guest of the evening, there were also present:—Drs. Goodhart, Stevenson, Shaw, Washbourn, Sykes, Gruggan, Worner, Messrs. Lucas, Cock, Golding-Bird, Shirley Murphy, Josephs, Symonds, Rowell, Pakes. Many letters of regret were received from other Guy's men unable to be present.

After dinner, the Chairman, in an excellent speech, proposed the health of Dr. Turner. In the course of his remarks he pointed out that the great advance that had taken place in sanitary science was in a large measure due to medical men, and more especially to that body of them, the medical officers of health. They had shown themselves ever ready to put forth their best energies on behalf of the health of the community. Dr. Turner had distinguished himself as few had done in this respect, and while he—the speaker—regretted that their guest was severing his connection with the Medical School of Guy's, everyone would rejoice at the honour which had been conferred upon Guy's by his appointment as Medical Officer of Health to Cape Colony.

The toast was received with great enthusiasm.

Dr. Turner, in acknowledgment, expressed his thanks for the kind manner in which he had been entertained. He could assure his hearers that it was with very mixed feelings that he was leaving Guy's. His connection with the institution had been a very happy one, and though, of course, he appreciated the honour which the Government of the Cape of Good Hope had conferred upon him, yet he could not leave Guy's Hospital without the sincerest regret.

Dr. Stevenson and Mr. Shirley Murphy replied to the toast of "Sanitary Science."

Dr. Goodhart proposed the health of the Chairman, which was responded to by Dr. Pye-Smith, who then proposed the health of Mr. Symonds, the secretary. This having been duly acknowledged, the proceedings terminated.

The following are a few of the many interesting incidents in the career of Dr. Turner:—

Born at Portsea in 1848, he received his early education at Hyde Abbey, Winchester.

At a very early age he was obliged "to black the eye' of a grandnephew of Shelley, the poet. "The little affair came off in Christchurch Churchyard, within a few yards of his great relative's monument. There was very little of the poet about Tom Shelley, besides he had said rude things about me." At Dr. Behr's school, Winchester, where the bigger lads were prepared for Sandhurst, Mr. Turner, after a very chilling reception from the "aristocracy" of the school, became at once a "Radical." He soon showed his independence by absolutely refusing "to fag, and in consequence led an exceedingly active and exciting life."

The son of a silk mercer of Portsea, Mr. Turner was at first intended to follow in the steps of his father, at the same trade, and to this end was sent to Paris when 15 years of age, to learn the business. He studied French to advantage and also received instruction in painting under the guidance of Justin Ouvrier.

In Paris he was treated with the greatest kindness by his father's friend, Albert Jodon. He eagerly seized the opportunities afforded him of improving his French, and was most indefatigable in learning the details of his business. He was extremely fortunate in the society of Albert Jodon, who was "a delightful man, a good classic, speaking English perfectly with a good accent."

During the following five years Mr. Turner was occupied in business in the French capital, in Bath and Portsmouth, and was for a short time at Goode and Gainsford's in the Borough.

He had no great liking for business, however, and much to his father's chagrin, he decided to enter Guy's. His father was at first entirely opposed to the idea his son had "to walk the hospital"; but, happily for Guy's, was at length prevailed upon to give his consent to the step. Two years from his entry, 1868, it was discovered by Dr. Owen Rees that Mr. Turner had phthisis, and he went to Montpelier, where, after having been arrested as an "Espion Prussien," he became chef de clinique at the Hospital St. Eloi. In 1871 he returned to Guy's, and the following year obtained the diplomas of M.R.C.S., L.R.C.P. Shortly after this he was appointed Resident at the London Fever Hospital, and in 1873 received the appointment of Medical Officer of Health to the Borough and Port of Portsmouth, and Public Analyst to the Borough of Portsmouth. Three years later his abilities were recognised by the local authorities, when he became Assistant Physician to the Portsmouth Fever Hospital, and at the same time he obtained the D.P.H., Cambridge. He prosecuted his researches in hygiene and public health, and in 1876 received the appointment of Physician to Portsmouth Fever Hospital. He subsequently became Surgeon to the Portsmouth Police, and Medical Officer of Health to Herts and Essex Combined Sanitary Districts, and in 1882 received the appointment of Lecturer of Hygiene at his old school, an appointment which he has held up to the time of his recent retirement. During 1886 Mr. Turner obtained the degree of M.B. Cantab, before doing which he was obliged to make frequent weekly journeys up to Cambridge to keep term. At the same time he was very busily employed at Guy's, and he must have shown no little perseverance and ingenuity in fitting in his work here and at Cambridge. The same year he wrote a valuable report for the Local Government Board on Diphtheria.

In 1890 he became Extra-Examiner for the D.P.H. Cambridge, and 1891 Examiner for the same diploma of the Conjoint Board. These appointments he has now resigned to enter the service of the Government of the Cape of Good Hope, as Medical Officer of Health to Cape Colony.

His experiences at Guy's cannot be more feelingly summed up than in his own words: "I came to Guy's in 1868; if I have not been happy ever after, I have been very nearly so."

Passim.

IT has been our mournful duty during the current year to record an unusual number of deaths amongst Guy's men, past and present. We have hardly recovered from one shock when another comes bringing fresh sorrow in its train. The announcement of the sudden death of Mr. George Lawrence—one of our most distinguished students—which occurred at Siena, has been received with very deep regret. He had been spending a holiday in Italy, and only recently had written to say how happy he was, when he was suddenly taken ill on Wednesday, July 3rd, and died of "brain-fever" eight days afterwards.

IT was not perhaps generally known when Mr. Leete received the Gurney-Hoare Prize from the Master of the Salters' Company on July 3rd, that he was to be the last recipient of this valuable award. The twenty years during which this prize was offered for competition has now passed, and Mr. Samuel Hoare, who has annually presented it, deserves the best thanks of the School for the stimulus that has thus been given to Clinical study.

BEFORE we have had time to recognise our loss, a former student of this Hospital, Dr. Richard Bredin, of Valparaiso, has generously forwarded a sum of money to continue this, or a similar prize of the annual value of £25, for a further period of five years. We would take this opportunity, on behalf of our fellow-students, of returning our best thanks to Dr. Bredin for his valuable gift.

WE understand that the conditions under which the Bredin Prize will be awarded will be announced in the New Green book, which is now in the press. We call it the Bredin Prize, for by that name it will certainly be known, even though the authorities should officially accede to the donor's modest request that it should not bear his name.

THE members of the British Medical Association have been invited to visit Guy's Hospital on Friday, August 2nd, between the hours of three and six o'clock, when the Hospital buildings will be open for inspection, and refreshments provided. The students are invited to attend on the occasion, and it is to be hoped that they will assist in showing the visitors the many places and objects of interest in the Hospital.

THE Hospital for Consumption and Diseases of the Chest, Brompton, having been recognised by the Conjoint Board for England as a place where, under the present curriculum, six months of the fifth year may be spent in clinical work, it has been decided to extend the facilities which it affords for the study of diseases of the chest with a view to meet the requirements of advanced students. To meet this end three courses of lectures and demonstrations will be given during the year by the Medical Staff, and Clinical Assistants in the Out-patient Department and in the Wards will be appointed from students who have attended the practice of the Hospital.

IT is almost ancient history now that at the recent Amateur Athletic Championships, Mr. H. A. Munro won the Four Miles' Championship. We believe that Munro is the first amateur champion who hails from Guy's. We hope he will not be the last. This achievement—accomplished in just under twenty minutes—has brought to a most fitting conclusion a brilliant athletic career, an account of which appeared in our last issue. We can assure Mr. Munro that Guy's is no less proud of the man who has done so well in the athletic world than of the honours he has won for us throughout the period he has been at the Hospital.

HAVING held the Inter-Hospital Cup without a break for the past five years, Guy's suffered a crushing defeat at the hands of University last week. We were badly beaten at every point of the game by a better team. The Cup has gone to St. Thomas's, who vanquished the University XI. in a somewhat easy and surprising fashion by seven wickets.

GUY'S has been doing well at Water Polo, and they are to be congratulated on their success over St. Thomas's—last year's holders of the Cup—by two goals to one. We hope that they will meet with equal success against St. Bartholomew's in the final tie on Thursday next.

BOTH our Cycling and Shooting Representatives are also to be congratulated. The former did well to make a tie with London for the Mellin Shield, while the latter very nearly secured the Bisley Cup from the powerful St. Thomas's contingent.

Obituary.

George Lawrence,

M.R.C.S. Eng., L.R.C.P. Lond.

The news of the sad and sudden death of George Lawrence was received at Guy's early this week. To us who had known and worked with him it came as a blow that we shall not soon recover from, and the memory of the man is surely one that will not easily be obliterated. Educated at Eton, and going later to King's, at Cambridge, Lawrence, in his life and in his work, was a protest against the spirit of routine and self-complacency. Perhaps the note which will dwell longest in our memories is the spirit of thoroughness which characterised him in all things, whether it was, as in early life, athletics and sports, or, as in later years, letters, poetry and art. Lawrence threw himself into each thing that he took up with a tireless energy and a determined will to get at the bottom of the thing in hand. He had *no dilettante interest* in anything. United with this sense of the reality of things was a capacity for dispatch and perseverance which are unique, applied as it always was by him to science, letters, and what perhaps is more rare, to the practical details of hospital work. Of his other and varied attainments this is not the time to speak—they are within the memory of contemporaries, but it *is* worth while to recall those generous enthusiasms of his, his eager and it may be boyish delight in the Kelmscott, Keats, and Shelley, the Edinburgh Stevenson, etc., and his native and passionate admiration of George Borrow. All these are memories which will long linger in hours of reverie for those who knew him.

With his keen interest in the Renascence, one can well imagine with what delight he lived just lately, in the quiet town of Siena, and perhaps his friends who were looking forward with great expectations for the effects of Italy on him will see something *more* than the natural irony of things in his death, at the early age of 27—cut short too when, as it seemed, he was enjoying a quite unusual sense of self-possession—the possession of his own best and happiest self, and was now, at last, in the attainment of a "flawless serenity." D.

Guy's Hospital Debating Society.

THE adjourned General Meeting will be held on Saturday, July 20th, in the Surgical Class-room, at 12.30 p.m.

BUSINESS.

1. Motion to alter Rule 4, so as to read—"That the Committee consist of six Members, in addition to the President, Vice-Presidents, and Secretaries." Proposed by Mr. E. Coleman.
2. Election of three Members of Committee.
3. Mr. Spon will give notice of a Motion concerning a revision of the Rules.

M. HAMBLIN SMITH, }
ROBERT HOWARD, } Hon. Secs.

Introductory Lecture to the Course on Materia Medica and Therapeutics.

DELIVERED AT GUY'S HOSPITAL, MAY 5TH, 1874,
BY W. MOXON, M.D., F.R.C.P.,
Physician to the Hospital.

(*Concluded.*)

The first of these plans, that which seeks to act on a knowledge of causes, is called the rational system; the second which seeks to recognise the disease and apply known cures, is called the empirical system. Now, when you hear that one system is rational and the other empirical, no doubt can exist as to which you incline to prefer. But it is not fair to suppose that the first plan is really the more rational, in the sense of being prudent and proper, because it is called so, any more than it is fair to suppose the Liberal party, so called, is not really more mean than the Conservative party, because it has laid hold upon the name which carries so favourable an impression. I say this, because you often find writers talking up the first plan as rational, as though it had the Goddess of Reason at least, if not Wisdom herself, on its side. But a little consideration will show you that the proper name of such a plan is the *deductive* system, not the rational system; for it professes to act by deduction from general truths already acquired or supposed. If you call this system by its proper descriptive name, *deductive*, then this name, instead of giving it a false colour of superior virtue, shows its inherent weakness. The plan assumes that we know enough to act upon about the causes of disease.

Gentlemen, it is difficult to speak in measured terms of the horrible results that have followed from this fatal assumption. It is this *irrational deduction* which has been the curse of medicine in all ages. This deduction, so irrational, is drawn from principles generally entirely false, and always so incomplete as to be beyond all bounds insufficient, so as to be often worse than false in their effects, even if true in themselves; yet you hear some describing the deductive, or the so-called rational, system as the pride of medicine. And those who have said this are so great, and so justified in feeling what the pride of medicine really is as a sensation, that one must submit; only replying that, if it be the pride of medicine, it has been the fatal curse of patients who have been hurried into the next world with the lancet or brandy-bottle on rational principles. Gentlemen, believe me these deductive systems are not rational; they are deductive on insufficient grounds, and hence are the opposite of rational in any commendable sense of that term.

I will not detain you long on such systems, but will try to explain on very simple principles some things that are commonly admitted as worth notice; such as the Brunonian system, the doctrine of Rasori, the homœopathic and allopathic systems, which, though usually regarded by honest physicians with proper contempt, are nevertheless not unfair, though coarse examples of

rational systems generally. To properly grasp these systems, it will be well to go through a little reflection of a psychological kind, but very elementary in degree. The simplest of mental phenomena is the perception of more and less. I say this is the simplest, because it takes consideration of only one property, that of degree or size. The simplicity of the notion more and less gives it a deep hold in our nature; and this is increased by the fact that it is so well beaten into all young human beings at school in their boyhood, in the shape of arithmetic and algebra, which are its higher developments, that it becomes the most fundamental part of their mental organization. The consequence is, that all our lives afterwards the reasoning faculties operate most easily in the directions more and less, *plus* and *minus*; and, from a rational point of view, they are most disposed to consider things as varying in that simple relation. In medicine by system, accordingly, you find the easy notion more and less come forward very readily, and you will see that, with only the adoption of special words, it constitutes the Brunonian system and the doctrines of Rasori, of Broussais, and others. To make the Brunonian system, Dr. Brown gets the notion that life is all stimulation, but sometimes more stimulation and sometimes less stimulation; and when there is a certain degree of more or less stimulation, then either of these states make disease. Therefore, you must find some way, in the first case, of bringing down the stimulation with lower stimulants, and in the second of bringing up the stimulation with higher stimulants. The doctrine of contra-stimulus of Rasori differs only in that what Dr. Brown called less stimulation Rasori thought to be the opposite of stimulation. As, however, neither of them could know whether it was so or not, we need not follow the arguments. Nothing could be more rude and futile than the attempt to consider all the various diseases and remedies as simply more and less, when differences of kind are so evident and important among them.

To turn, then, to the various kinds of -paths. The deductive mind, overpowered by an excess of the arithmetical and disciplinary conception of more and less, makes a Brunonian. In a parallel way, the same sort of mind, engaged by the conception of like and unlike, becomes some sort of a -path—say, usually, a homœopath. The notion of like and unlike grows very early in babyhood; it is, unfortunately, not much subject to discipline at school, but is allowed to be loose in young people, and so it grows up loose in them when they are older; so that commonly, adults do not mean anything very accurate by the statement that one thing is like another. Perhaps, to say that one thing is like another is the weakest thing you can say about it; the likeness may be poetic, or comic, or simply delusive, making you mistake one article for another, so that you do the wrong thing with it. The result is, that adults often require to be told that they mean sometimes one thing and sometimes another by likeness, and are then, perhaps, as surprised as M. Jourdain when he learnt he had been talking prose all his life. When like has any strictness at all, it means identical. It means that or nothing. Follow me carefully for a moment. A thing that is entirely like another thing is entirely identical with it. A thing that, without being entirely like another thing, is yet like it for some purposes sufficient for the meaning at the time, is *identical* so far as those purposes are concerned. In short, likeness is identity *so far as the word like has any force.* Stones of the same shape and size are alike for the mason; if they are of different durability, they are not alike for the house-owner. "Yahoos" are like men for the purpose of being laughed at. Thus likeness may be defined as *identity for the purpose in question.* Yet the term like is, from boyhood, used so fast and loose, from the likeness of equilateral triangles to the likeness of Jack to a monkey, that, when the boy grows into a homœopath, he is ready to attach any meaning to like, from identity to the most fanciful resemblance. Now, in a general way, people believe that unlike things oppose each other, whether these unlike things are diseases or any other things. Such a notion is not worth much, unless you apply it strictly; but, in the only sense in which it has a strict application, it is an identical proposition; for you mean really opposite by unlike, or else you do not mean anything definable. You mean opposite so far as unlike; so that your proposition is that opposite things oppose each other so far as they are opposite—a proposition of infantile simplicity: true, surely, and cogent wherever applicable. It is so evident, that I do not think any school of doctors ever proclaimed it; if they did, they would be allopaths.

But a notorious person named Hahnemann, taking advantage of the fact that doctors, who proceed according to common sense, do not save everybody from dying, rose against common sense, and said like cures like—*similia similibus curantur.* Then was seen how unhappy it is that this idea of like is left at school in such undiscipline; for a whole crowd, ready for something new, go after him, not knowing how to deal with so manifold a thing as likeness, and not caring what it means. But if you examine the proposition "like cures like," you see its puerility, so far as it has any apprehensible meaning. We have seen that likeness is identity so far as the word has any force. It is practical identity of quantity, if quantity is being considered; of colour, if colour is being considered; and so on. Thus Hahnemann's proposition, so far as it has any accurate or apprehensible meaning, is that identical things have opposite results; nothing being said about the fulcrum which alone could make the arrangement rationally possible.

But it may be said that the cure and the disease are not really alike, but only appear alike. Then the proposition has to be changed to—apparently similar things cure each other. That assumes that things are made to have likenesses the opposite of their real natures; and a proposition of that kind is in every way too empty to be further noticed. Hence we may dismiss homœopathy from consideration, especially as the practice of its professors really no longer differs from that of doctors who do not adopt its absurdities. Indeed, the system

is well known to have degenerated into a means of attracting the notice of the public by means of globule boxes and tinctures.

It is worth while to thus consider these coarse examples of deductive systems of therapeutics, not on account of their worth, but because you will find that all deductive systems of medical therapeutics, even when far less pretentious and vain than homœopathy, are really irrational, if less flagrantly so. And I could, if I had time, show you that it is by the forcing of puerile and crude deductions that all rational schools arise in medicine. Such schools are nothing more respectable than boyish notions of quantity and likeness, etc., brought by weak men into complex realities to which they are wholly inapplicable; so that at best such systems are as though children should be taught to play about with poisons at the tables where confiding guests are accustomed to seek refreshment.

What you want in the practice of medicine, is a close and well-trained observation of the descriptive nature of the kinds of diseases, and of the effects of drugs on them. You must know these well, or you ought not to have an easy conscience. You must be able to recognise the several kinds of disease, and to use the remedies that are best for each kind. Mistrust plans of treatment, in proportion as the reasonings they are founded on are deduced from abstract considerations. Beware of the reasonings in medical therapeutics. I shall have to show you that there is scarcely an exception in medicine to this rule, that all deduced general plans of treatment have been pernicious; that deductive reasonings have been the curse of medicine—I mean of patients. Those who have well observed the results that actually follow, when remedies are used under well-recognised conditions, are the real benefactors of the sick. A steady process of induction is what we want; induction, often in its humblest degree, which shall often give a scarcely communicable experience to guide the watchful physician. Such inductions as that quinine cures ague, iodide of potassium cures tertiary syphilis, tarry preparations cure scaly eruptions, are the best stock of even nineteenth century medicine; and, however mean in the scale of mental performances, are of priceless value in the shivers of intermittent fever, the tortures of cranial syphilis, and the itch of psoriasis, with which you have to do. Such inductions are commonly in harmony with the teachings of physiology; but I advise you to hold them a good deal distinct from those teachings, and do not be too ready to allow them to rest, even in appearance, on those teachings.

In what I have to say on the several drugs, I shall follow the order of the therapeutic divisions in Dr. Garrod's work, which I recommend to you. We shall have an opportunity of noticing, in succession, the sorts of actions on the human body which the various drugs possess. My object will be to introduce to your notice each medicine in the position it has in such a therapeutical scale. Very often you will find that a medicine has several uses, and in giving the notice of the history of each, I shall take all its important powers into consideration; but I shall try to bring the several medicines into that part of the scale of which they are most typical and proper representatives.

Chapel News.

WE have to gratefully acknowledge some offerings of flowers and two of money (amounting to 8s.) for Chapel decoration.

We are very sorry to have to announce that Sister Cornelius is leaving the Hospital and has therefore resigned the office of Sacristan. The Matron has kindly consented to undertake the work in future. Any future gifts should be sent to the Home.

The offertory for the Bondee Famine Fund on Thursday, July 10th, amounted to 22s. Any further contributions should be enclosed in paper, marked "Famine Fund," and placed in the offertory bags at any of the celebrations in July, August and September; or they may be forwarded to the Secretary, Universities' Mission to Central Africa, 14, Delahay Street, S.W. In the Chapel porch will be found all particulars relating to the fund.

The proposal to form "an Association of Ladies in connection with Guy's Hospital, with the object of enabling its members to take an active interest in the social welfare of the patients" (*vide* the GAZETTE of July 6th), is one that most sensible people will be prepared to welcome, though at this stage they may not find it easy to give an opinion as to its practicability. Our purpose in alluding to it is to base thereon an appeal to students, nurses, etc., to consider how much evil is done by indiscriminate alms-giving. A dole of a few shillings does, no doubt, a certain amount of good at the moment, but experience shows that in the long run more evil than good is the result. But, above all, it should be known that this kind of work is well cared for at the present time. Not to dwell upon the good work done by Matron, Sisters, and Medical Superintendent out of the Samaritan Fund, and by means of such assistance as they can gather from their own circles of friends, we may point out that the "Flower Mission Ladies" have for the last twenty years made it their business, not only to relieve cases on leaving the Hospital, but have also done most valuable work in following some of the patients to their own homes. And, to complete the tale, the Chaplain sits every Wednesday on a local Committee of the Charity Organisation Society to see what can be done for deserving people who may have escaped through the meshes of our charity-nets.

It was very gatifying to our organist, Mr. Rich, to see how much his Organ Recital was appreciated on Prize Day. He had a larger number of hearers than on any previous occasion.

Review.

The Deformities of the Human Foot, with their Treatment. By W. J. Walsham, M.B., C.M. Aberd., F.R.C.S. Eng., Senior Assistant-Surgeon to St. Bartholomew's Hospital; and William Kent Hughes, M.B. Lond., M.B. Melbourne, Orthopædic Surgeon to St. Vincent's Hospital. (London: Bailliére, Tindall & Co.) Price 18s.

This profusely-illustrated volume gives a very complete account of the deformities of the foot, and hence forms an invaluable book of reference. The authors commence by describing the anatomy and mechanism of the normal foot, entering fully into all details which bear directly upon the subject in hand, and giving a most interesting account of the mechanism of standing, walking, etc. They next give full descriptions of the various kinds of talipes, discussing in detail their pathology and treatment. The most interesting part of this section is the one devoted to the etiology of congenital talipes varus, and this portion deserves the most careful perusal by all those who are specially interested in the subject. Acquired talipes valgus or flat-foot is dealt with at considerable length, its pathological anatomy and treatment being exhaustively treated. The book concludes with chapters upon hallux valgus, varus and dolorosus, hammer-toe, and deformities of the small toes. Considering the great value of the book as a monograph upon a difficult branch of surgery, it is unfortunate that the treatment of the subject should be at times somewhat sketchy, and should in places appear to consist rather of a collection of notes than of a continuous and connected account of the whole subject.

The Bermondsey Settlement.

ABOUT thirty students attended a meeting held on the 11th instant, in the new Chemical Theatre, to promote interest in the work of the above Institution. Mr. Wade and Mr. F. G. Hopkins, who are interesting themselves in the movement, were present, in addition to the Warden, the Rev. J. Scott Lidgett.

Mr. Lidgett made a strong appeal to those present for help in the crowded districts of Rotherhithe and Bermondsey, in which neighbourhood the Settlement is doing extensive and lasting good among the lower classes. The Warden especially asked Guy's students to take up residence at the Settlement, which they can do at very moderate terms ranging between one guinea and twenty-eight shillings a week. The neighbourhood is healthy and quiet and is within easy reach of Guy's by train or tram. It is understood that all residents are in sympathy with the aims of the Settlement, which is unsectarian, and the variety of the work carried on by the Settlement affords a valuable training in philanthropic work to those who have some leisure. We are glad to hear that Mr. Lidgett's appeal has already borne fruit and that several of our students have promised to help Mr. Hopkins in a series of practical chemistry classes. Help is needed in ambulance classes, in scientific and religious work, and in the various athletic clubs, cricket, football, swimming or gymnastic. There must be some amongst the very large number of our students who do take an intelligent interest in the splendid work which such institutions as the Bermondsey Settlement are doing towards ameliorating the condition of the toiling masses of this country, who have the time and the inclination to help Mr. Lidgett, and we hope that they will come forward to take the place of those—many of whom are Guy's men—who are no longer able to render assistance. Mr. Lidgett has informed us that any Guy's man who would like to be shown over the rooms of the Settlement is requested to communicate with him by letter to the Bermondsey Settlement, Farncombe Street, Jamaica Road, S.E.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

R. J. R., LOWESTOFT.—Microscopic examination of the membrane showed the presence of typical diphtheria bacilli with a large admixture of cocci as staphylococci and a long slender bacillus. After 24 hours' incubation on blood serum several suspicious colonies had made their appearance which microscopically proved to be composed of the Klebs-Löffler bacillus.

W. A. M.—KIDDERMINSTER.—Both specimens show merely chronic inflammatory changes, and there is no evidence of malignant disease. The gland presents a few small foci of suppuration.

F. H., NEW FERRY.—Microscopic examination of the serum showed the presence of a staphylococcus (probably the staphylococcus pyogenes albus) in large numbers, whilst a blood serum cultivation gave abundant colonies of the same organism at the end of 24 hours.

J. R. A., SHERBORNE.—Microscopic examination of the deposit shows the presence of a few hyaline tube casts and crystals of urate of ammonium and calcium oxalate, squamous epithelial cells and a small number of granular leucocytes were also noted.

J. M. B., BURGESS HILL.—*Morning.*—Reaction acid, sp. gr. 1009; albumen, sugar and blood absent. Microscopical examination of the deposit of the centrifuge shows the presence of numerous squamous epithelial cells from bladder and vagina, and a few uric acid crystals. No tube casts could be detected. *Night.*—Reaction acid, sp. gr. 1009; sugar, blood, albumen absent. Microscopical examination of the deposit shows the presence of crystals of calcium oxalate and large quantities of squamous epithelium. A few granular leucocytes were also noted, but no tube casts could be found.

PATHOLOGIST.

Sport.

Cricket.

SEMI-FINAL CRICKET CUP TIE.

GUY'S v. UNIVERSITY.

Played at Honor Oak Park, July 8th. Teams—

GUY'S.

A. Perks, b Moffit	9
A. E. Clarke, b Moffit	14
K. B. Alexander, b Capper	14
F. J. Nicholls, b Moffit	4
N. Lavers, b Capper	0
E. D. Hancock, b Capper	0
L. Humphry, not out	16
F. R. Featherstone, b Capper	0
B. B. Ham, run out	3
P. D. Hunter, b Capper	7
E. J. Goddard, b Capper	1
Extras	10
Total	78

UNIVERSITY.

C. E. Marriott, c Humphry, b Lavers	23
H. C. Pretty, b Clarke	14
A. C. Hackney, b Clarke	9
H. G. Capper, b Nicholls	48
M. Glover, c Hancock, b Ham	6
A. W. Ricketts, c Hancock, b Perks	56
G. H. B. Stanley, run out	0
C. G. Moffit, b Clarke	7
C. H. Bidwell, run out	109
N. F. Stallard, not out	49
F. R. Barwell, c Lavers, b Perks	9
Extras	18
Total	348

GUY'S v. STREATHAM.

Played at Honor Oak Park, July 6th. Teams:—

STREATHAM.

	1ST INNINGS.		2ND INNINGS.
C. J. Francis, lbw, b Harris	14	run out	32
N. Pike, b Clarke	0	c Clarke, b Nicholls	7
L. Mortimer, b Clarke	9	c Ham, b Grace	8
—. Lees, b Harris	18	c and b Ham	3
E. T. Shorland, b Harris	8	not out	34
A. N. Morley, b Harris	16	run out	9
W. R. Smith, b Harris	7	c and b Ham	0
—. Russell, b Goddard	13	not out	10
C. A. Tomkins, not out	11		
M. Leach, b Goddard	6		
W. S. Trollope, b Harris	3		
Extras	11	Extras	6
Total	116	Total	109

GUY'S.

A. E. Clarke, b Mortimer	29
F. J. Nicholls, lbw, b Mortimer	10
K. B. Alexander, c Smith, b Lees	2
—. Harris, c Smith, b Lees	7
A. H. Grace, c Trollope, b Shorland	13
N. Lavers, b Lees	1
J. J. E. Biggs, lbw, b Francis	19
L. Humphry, b Lees	14
B. B. Ham, b Francis	15
P. D. Hunter, not out	5
E. G. Goddard, b Francis	6
Extras	2
Total	123

GUY'S v. BRENTWOOD.

Played at Honor Oak Park, Saturday, July 13th. Teams:—

BRENTWOOD.

C. Escott, b Harris	10
R. Shepherd, c Nicholls, b Wetherell	37
H. Nomersley, b Harris	1
A. Heathley, c Alexander, b Harris	17
R. H. Raphael, c Harris, b Wetherell	9
—. Cutts, b Harris	3
C. E. Lewin, c Briggs, b Wetherell	1
F. Couch, b Wetherell	18
S. R. Ralli, c Briggs, b Lavers	4
H. E. Oliver, b Harris	20
H. Berkeley, not out	17
Extras	7
Total	144

GUY'S.

A. Perks, b Heatley	54
K. B. Alexander, run out	21
F. J. Nicolls, b Heatley	4
N. Lavers, b Cutts	0
—. Harris, b Heatley	20
E. D. Hancock, run out	10
J. J. E. Biggs, b Heatley	5
F. C. Wetherell, not out	44
L. Humphry, b Couch	4
H. Hewetson, b Heatley	7
C. H. Fagge, c Escott, b Heatley	0
Extras	20
Total	190

GUY'S 2ND XI. v. ST. BART'S. 2ND XI.

This match, played at Winchmore Hill on the 10th July, proved a very close and exciting game. Palmer once more did the lion share and came off both in batting and bowling. Bart's are to be sincerely congratulated on their splendid ground and particularly nice and well-arranged pavilion. The only pity is that it is quite so far away. Teams:

ST. BART'S.

G. Wedd, c Palmer, b Lavers	24
H. Godwin, b Palmer	9
H. Pickering, b Palmer	0
J. Collyns, b Palmer	2
T. Body, c & b Lavers	11
F. Nimmo, b Lavers	10
D. J. Drake, c Slater, b Palmer	1
F. Pravis, b Palmer	2
C. Turner, b Lavers	1
H. Baylis, not out	0
A. Bostock, c Anderson, b Palmer	2
Extras	24
Total	87

GUY'S.

T. Morgan, b Collyns	3
C. T. Anderson, b Collyns	3
N. R. Lavers, c Drake, b Turner	15
E. G. Goddard, b Collyns	12
L. Humphry, c Godwin, b Turner	6
G. K. Levick, b Collyns	2
W. G. Palmer, b Pickering	24
G. D. Slater, not out	19
H. Bignold, c Pravis, b Pickering	4
W. M. Thomas, b Pickering	1
A. E. Cawston, b Nimmo	10
Extras	15
Total	114

Cambridge University v. United Hospitals.

The following is a detailed account of this meeting, which took place at Stamford Bridge on the 26th ult.:—

100 YARDS.—H. C. Woodyatt, U.H.A.C., 1; E. H. Wilding, C.U.A.C., 2; G. Gomer-Williams, C.U.A.C., 3; R. G. Murray, U.H.A.C., 4. Won easily by a yard and a half. Time 10⅗ sec.

440 YARDS.—W. Fitzherbert, C.U.A.C., 1; C. H. Lewin, C.U.A.C., 2; A. G. Butler, U.H.A.C., 3; F. S. Batchelor, U.H.A.C., 4. Fitzherbert took the lead early, but drew away from Butler who was passed in turn by Lewin. The winner led by 6 yards, 3 between 2nd and 3rd. Time, 51 sec.

HIGH JUMP.—A. B. Johnston, C.U.A.C., 5 ft. 7½ in., 1; S. G. Lubbock, C.U.A.C., 5 ft. 6½ in., 2; G. W. Stone, U.H.A.C., 5 ft. 5½ in., 3; S. F. Smith, U.H.A.C., 5 ft. 4½ in., 4.

120 YARDS HURDLE RACE.—L. E. Pilkington, C.U.A.C., 1; P. R. Lowe, U.H.A.C., 2; H. W. Coltart, U.H.A.C., 3; D. M. Fletcher, C.U.A.C., 0. This was a fine race between Lowe and Pilkington, over the last two hurdles they were level, but the latter getting into his stride in the run home, won by a foot. Coltart 2 yards behind Lowe. Time 16½ sec.

PUTTING THE WEIGHT.—W. G. West, U.H.A.C., 37 ft. 10½ in., 1; W. F. Bennett, U.H.A.C., 37 ft. 5½ in., 2: E. G. M. Watson, C.U.A.C., 36 ft. 9 in., 3; C. T. de la Pyme, C.U.A.C., 0.

LONG JUMP.—W. Mendelson, C.U.A.C., 21 ft., 1; C. E. H. Leggatt, U.H.A.C., 20 ft. 11 in., 2; W. McG. Hemingway, C.U.A.C., 3; J. W. Nunn, U.H.A.C., 4.

ONE MILE.—W. E. Lutyens, C.U.A.C., 1; A. G. Butler, U.H.A.C., 2; H. Davenport, C.U.A.C., 3; C. H. Lewin, C.U.A.C., 0; P. W. James, U.H.A.C., 0; H. E. Finch, U.H.A.C., 0. This was an easy thing for the Cantab, who won by nearly 100 yards. The times for the laps were ¼-mile, 1 min. 1 sec.; ½-mile, 2 min. 6 sec.; ¾-mile, 3 min. 14 sec. 1-mile, 4 min. 20⅕ sec.

THREE MILES RACE.—H. A. Munro, U.H.A.C., 1; F. S. Horan, C.U.A.C., 0; H. V. Wood, C.U.A.C., 0; G. H. Todd, C.U.A.C., 0; H. Mundy, U.H.A.C., 0. Ford led for the first mile, when Horan took up the running, followed by Munro, and these latter were the only two left on the track at two miles. Munro passed the leaders at the beginning of the last lap, and Horan stopped shortly afterwards very much exhausted. Munro finished alone. The times were, 1-mile, 5 min. 2½ sec.; 2 miles, 9 min. 55½ sec.; 3 miles, 14 min. 48 sec.

THROWING THE HAMMER.—A. P. Johnston, C.U.A.C., 108 ft 2½ in, 1; J. S. Mackintosh, U.H.A.C.. 93 ft 11 in, 2; C. J. de la Pryme, C.U.A.C., 87 ft 11½ in, 3; E. N. Scott, U.H.A.C., 86 ft 4 in, 4.

1,000 YARDS INVITATION HANDICAP.—B. Lawford, S.L.H., 57 yards, 1; A. W. Andrews, L.A.C., 42 yards, 2; E. C. Bredin, L.A.C., scratch, 3. Also ran: E. J. Wilkins, L.A.C., 23 yards; C. S. Sydenham, L.A.C., 40 yards; A. Hay, St. Bartholomew's, 60 yards; P. G. Mould, St. Mary's, 72 yards. Hay took the lead from the first, but was unable to stay, Lawford winning by six yards; Andrews beat Bredin by two yards. Winner's time, 2 min 16⅘ sec; Bredin's time, 2 min 11⅗ sec., 4 sec more than record made by Myers, at Birmingham, in 1884.

United Hospitals' Cycling Association.

ANNUAL INTER-HOSPITAL RACE MEETING.

There is no branch of sport in which Hospitals' men have shown a more conspicuous excellence than in cycling. One has only to mention the names of Cortis and Furnivall to prove that here, as in cricket, the very finest performers have been members of the medical profession; and, although our present riders have accomplished nothing comparable with the feats of those

former champions, many of them have ridden well enough to rank high among the cyclists of their day. It is therefore not a little surprising that the idea of an Inter-Hospital Cycling Contest was never carried into effect until last year, when St. Thomas's succeeded in securing the Challenge Shield, presented to the United Hospitals' Cycling Association by Mr. G. Mellin.

At this first Inter-Hospital race meeting, which included a One, Three, and Twenty Mile race, four hospitals—St. Thomas's, Guy's, University College, and the London—took part. Only the first three men in each race scored points towards the Shield, and of them the winner counted 3, the second 2, and the third 1. As before mentioned, St. Thomas's won, but it was only by a single point, and the result would probably have been different, had it not been for the carelessness of the officials, who allowed the riders in the mile race to get half way round the last lap before the bell rang. In consequence of this mistake, Milbank-Smith, who in all probability would have finished second, allowed himself to be shut in at the last bend, and, being unable to come through at the finish, could only secure third place. The point thus lost deprived Guy's of the trophy, which they might otherwise have held conjointly with St. Thomas's. It is curious to note how, in spite of their last year's experience, the Association allowed an equally fatal error to mar the success of this year's meeting.

The Second Annual Inter-Hospital Cycling Meeting was held on Wednesday, July 10th, 1895, at the same place, Herne Hill Grounds. The weather was almost perfect, the sun shining brightly, and scarcely a breath of wind blowing, and the track was in admirable order. A fair number of spectators, many of them ladies, was assembled on the grounds, both inside and outside the pavilion, but the attendance was quite unworthy of so important a race meeting; and so keen was the competition, and so excellent the form shown by the riders, that the absentees are indeed to be pitied.

The method of scoring points towards "the Mellin Shield" was quite different to that adopted last year. Instead of only the first three scoring, points were awarded to *all* the competitors in order of finishing, the Hospital with least points winning. This was the case in the first three heats of the Mile, and in the Three Miles and Twenty Miles races. The Final Heat of the Mile did not score towards the Shield.

By this new arrangement—the racing being no longer confined to the first few men—the competition was keener, and the finishes more interesting. But, with ten or eleven starters in a race, it was found difficult to place the men accurately. It was also most unfair in the Mile, inasmuch as the points scored by any rider depended almost as much upon what heat he was in as on how good a rider he was. In the Mile, too, it encouraged "loafing," as two members of the same Hospital were never in the same heat, and no rider was likely to destroy his own chance of winning by acting as pacemaker for a member of another Hospital; and the loafing so occasioned was not only objectionable to the spectators, but it sometimes allowed the wrong man to win, for the race went to the fastest finisher rather than to the fastest mile rider.

In the Three Miles where three competitors from each Hospital were allowed to start together, the pace was good throughout, and in the Twenty Miles, where pacing by tandems and other machines was permitted, a very fast time was accomplished.

As on the first occasion, four hospitals competed for the Shield—Guy's, Thomas's, and the London again opposing one another, whilst St. Mary's took the place of University College. Burke, of St. George's, and Harris, of Middlesex, were allowed to ride for the Mile Championship, but, seeing that their hospitals are not affiliated with the U.H.C.A., they were put in a heat by themselves and not allowed to score points towards the Shield.

The Mile Race came first on the card, and with it the competition started at about 3.15 p.m. Harvey, of the London, had, as had been expected, but little difficulty in winning the first heat, Hoskins, of Thomas's, being second. Guy's were represented by C. Reed, though Beadnell's name figured in the programme. Being both untrained and ill-mounted, Reed was unable to do himself justice, and he was beaten for third place by Dodgson.

The second heat was naturally considered "a soft thing" for A. F. Millar, of Thomas's, the last year's winner, but he left his effort till the finish, and when it came to racing, West fairly held him and got home with nearly a length to spare. The Guy's men were elated at West's unexpected victory, and confidently expected another win in the third heat, in which Milbank-Smith was opposed by Pooley, of Mary's, and A. S. Bruzaud, of the London, the honorary secretary of the Association; but the Guyite, having no one to take him along, and being unwilling to force the pace himself, waited behind till the last half-lap, when Pooley spurted, and, travelling the fastest of the three, drew right away and won somewhat easily. Milbank-Smith was certainly a good deal incommoded by the lowness of his saddle, but that is not sufficient excuse for his defeat, which must be ascribed rather to bad judgment in the race than to any fault of his machine. The fourth heat consisted of a waiting race between Burke and Harris. The former made the pace (?), the Middlesex man crawling along behind him for two and a half laps. Harris then closed with the George's rider, but the latter went the stronger of the pair, and finishing at a terrific rate, won by about six yards.

The points now stood, Guy's and Mary's 7 each, London 8, Thomas's 10. The Three Miles followed. There were eleven starters, Thomas's only sending two men to the scratch. Guy's were represented by Milbank-Smith and West, with Henry for third string, Beadnell again being a non-starter. Fast pedalling prevailed throughout the race, but the riders kept together up to the last half mile, and even at the finish they had not spread out much, so that there was difficulty in

accurately placing one or two of the men, and, in the excitement of doing so, the timing of the race was forgotten. Millar succeeded in turning the tables on his former opponent, West, who however rode splendidly. Milbank-Smith, though again too slow in the final spurt, was a good third. Henry fell with Hoskins near the end, but he quickly got back in the saddle, and finished tenth. In this race Guy's got 15 points, London 17, Mary's 22, Thomas's 24, and the total score therefore stood, Guy's 22, London 25, Mary's 29, Thomas's 34. It was thus still impossible to predict the ultimate winner, and this fact gave additional interest to the Twenty Miles later.

The final for the Mile included the four winners of heats. They were all well up at the finish, when Burke shot out and won from Harvey, West being close up, third.

There were ten starters for the Twenty Miles, Thomas's being represented only by Millar, between whom and Milbank-Smith a good race was expected. Many of those who had seen the latter win last year in only a shade over record time, expected him to repeat his victory this year. But the Thomas's man, being well paced from the start, led him by nearly two laps at three-quarter distance, and, though Milbank-Smith picked up a little towards the end, he could never again get within a lap of him. The Guy's man was certainly stale and not riding at his best, so could probably not have won under any circumstances. At the same time, it looked as if he was not taken along quite fast enough for the last four or five miles. At any rate he always kept close behind the tandem which paced him and finished quite fresh. Millar's time, 52 min. 7 sec., is good, though it is 1½ minutes behind Milbank-Smith's record. West rode well at first but dropped back before many miles had been covered. He is obviously better at shorter distances. Henry, who rode in place of Digby, started slowly, but was well up at the end of his thirtieth lap, when on rounding the first bend he upset, and falling heavily on the wood, was badly hurt. Nevertheless, finding that the success of Guy's might depend upon his finishing, he remounted after a few minutes, and with bleeding knees and bruised elbows rode on for another 32 laps. With Harvey and Noble, who both rode well, the London secured third and fourth places, but who was fifth? was it West or Tripe? That the question should have arisen reflects no credit on the officials, but it did arise, and it was a question of the utmost importance, for on that one place depended the supremacy of Guy's or the London. If West was in front Guy's had won; if Tripe had beaten him the Shield must go to the London.

It had been arranged that the race should terminate at the moment at which the first man passed the winning post, and that the position of the riders at that instant should determine the points they were to score. But unfortunately very few of the competitors were aware of this arrangement, and certainly the majority of the officials were also ignorant of it. The result was that the men were allowed to ride several laps after Millar finished, and as some had ridden two, some three or more laps after the race was over, it became difficult to tell what had been the order at the finish. West and his supporters were quite sure he had beaten Tripe, but the latter and his friends were equally convinced that he had not. Matters were further complicated by the unavoidable departure of one of the judges before the race had been ridden out, so that Mr. J. E. Dixon found himself in the unenviable position of having to decide this momentous question alone. He pursued what was certainly the fairest course under the circumstances, by declaring it a tie between Guy's and the London—a decision which, though it involved the ridiculous assumption that the two men had ridden a dead heat, gave almost universal satisfaction. Thus was amicably settled a dispute which might have caused a good deal of ill-feeling, and it is to be hoped the warning may lead to better management in future years. The final placings and points were:—

		Totals.
Guy's	7, 15, 15 ...	37†
London ...	8, 17, 12 ...	37†
Mary's	8, 22, 26 ...	56

and it is interesting to note that, had last year's method of scoring been adopted, Guy's would still have tied for the Shield, but it would have been with Thomas's instead of with the London, each hospital having scored ten points.

Our success was entirely due to three men—Milbank-Smith, West and Henry. The admirable riding of the former is all the more creditable when one remembers he is stale and over-worked, and we hope to see him at his best again next year. In West we have a most promising rider, who, with a little practice—for he is still a perfect novice on the path—ought to develop into something really good. But it is to Henry more than to anyone that we are indebted. No one can forget the marvellous pluck with which, after his fall in the Twenty Miles, he remounted, and eventually beat Spurgin, thereby just saving his Hospital from defeat.

That Beadnell and Digby should have allowed their names to appear on the programme, and then failed to turn out, shows a regrettable slackness, and a word of praise is due to Reed for his effort to atone for their failings.

At the conclusion of the racing, the prizes were distributed to the successful competitors by Mrs. T. Horrocks Openshaw; the Guy's and London teams going up together to take the Shield. We understand that the London are to retain it till the end of the year, and we look forward to seeing it at Guy's on January 1st.

Cheers for Mrs. Openshaw and an excellent speech from her husband, the President of the Association, brought this most enjoyable meeting to a close.

RESULTS:—

ONE MILE RACE.—Heat 1: A. T. V. Harvey, London, 1; C. Hoskins, St. Thomas's, 2; R. W. Dodgson, St. Mary's, 3; C. Reed, Guy's, 4. Heat 2: E. M. West,

Guy's, 1; A. F. Millar, St. Thomas's, 2; P. B. Spurgin, St. Mary's, 3; H. J. Bryan, London, 4. Heat 3: J. M. Pooley, St. Mary's, 1; H. J. Milbank-Smith, Guy's, 2; A. S. Bruzaud, London, 3. Heat 4 (unaffiliated members): J. Burke, St. George's, 1; A. H. Harris, Middlesex, 2. Final Heat (for prizes only): J. Burke, St. George's, 1; A. T. V. Harvey, London, 2; E. M. West, Guy's, 3; J. M. Pooley, St. Mary's, 4 Time, 2 min. 51⅕ sec.

Scores: Guy's, 7; London, 8; St. Mary's, 7; St. Thomas's, 10.

THREE MILES RACE.—A. F. Millar, St. Thomas's, 1; E. M. West, Guy's, 2; H. J. Milbank-Smith, Guy's, 3; W. J. Noble, London, 4; R. W. Dodgson, St. Mary's, 5; A. S. Bruzaud, London, 6; H. J. Bryan, London, 7; J. M. Pooley, St. Mary's, 8; C. H. Furnival, St. Mary's, 9; B. Henry, Guy's, 10; C. Hoskins, St. Thomas's, 11.

Scores: Guy's, 15; London, 17; St. Mary's, 22. Time not taken.

TWENTY MILES PACED RACE.—A. F. Millar, St. Thomas's, 1; H. J. Milbank-Smith, Guy's, 2; A. T. V. Harvey, London, 3; W. G. Noble, London, 4; E. M. West, Guy's, 5*; J. H. Tripe, London, 5*; R. W. Dodgson, St. Mary's, 7; B. Henry, Guy's, 8; P. B. Spurgin, St. Mary's, 9; C. H. Furnivall, St. Mary's, 10. Time, 52 min. 7 sec.

Scores: London, 12; Guy's, 15; St. Mary's, 26.

Total points for Shield: Guy's* and London*, 37, 1st; St. Mary's, 56, 3rd.

OFFICIALS.—Starter: H. A. Munro; Judges: E. B. Turner, Esq., F.R.C.S., and J. E. Dixon; Time-keeper, P. G. Mould; Clerk of the Course, A. Fawcett; Enclosure Steward, F. G. Hopkins, Esq., M.B., B.Sc.

Guy's Hospital Rifle Association.

UNITED HOSPITALS' CUP.

Bisley has again come round, and again we have to record St. Thomas's the winners of the Cup, but this time by the narrow margin of 10 points. The day was not all that could be desired, but was a distinct improvement on last year, the maximum wind velocity being only about 15 miles an hour. In the early part of the afternoon the team disported themselves in the "Railway" competition, and made therein scores ranging from 14 to 31, which did not promise anything great in the line of Cup scores.

Fortunately, however, the sky was overcast by 6 p.m. when the competition began, and except for a few occasional peeps the sun did not cause much trouble.

As in the last two years, all the teams were down together, so that no comparison could be made till the conclusion. Then it was found that Guy's was an easy second. It is satisfactory to be able to state that all our team acquitted themselves very creditably, all scores being greater than the highest last year. Special congratulation is due to Telling, who made 68, thus winning the Maw, Son and Thompson prize for the highest score in the whole competition. We were sorry not to have the cheering influence of a single present Guy's man, but this lack of patriotism was atoned for an old Guy's man, Mr. Rendall, who was under canvas during the meeting. At the conclusion of the match the team was entertained most kindly by Mr. Rendall in his tent, and the seating accommodation of the same was taxed to the fullest extent. Under inspiring influences the time was passed most pleasantly and we shall all remember the evening with great satisfaction. The team secured an empty compartment on the up journey, and a special vote of thanks is hereby accorded to Moss for his efforts in the vocalistic line. Scores:—

ST. THOMAS'S.

Hindley	66
Beley	65
Child	65
Brakenridge	59
Somers	55
Walker	50
	360

GUY'S.		ST. BART'S.	
W. H. Telling	68	Taylor	56
W. B. Secretan	61	Holmes	63
H. Fulham-Turner	58	Armitage	64
R. H. Ashwin	57	Brown	55
G. G. Ellis	54	Gask	46
B. W. Moss	52	Dunne	41
	350		325

ST. MARY'S.		CHARING CROSS.	
Smith	59	Lloyd	61
Woodburn	58	Staten	52
Hammond	56	Street	46
Wells	51	Spencer	40
Smith	53	Clark	28
Taylor	27	Walker	23
	304		250

Appointments.

OLDMAN, C. E., M.D. Cantab, has been appointed Medical Officer of Health for the Godstone Rural Sanitary District.

SEWILL, J. SEFTON, M.R.C.S., L.R.C.P., L.D.S., has been appointed Dental Surgeon to the St. Marylebone General Dispensary.

SYMONDS, CHARTERS J., M.S., M.D. Lond., F.R.C.S. Eng., has been appointed Consulting Surgeon to the Stockwell Orphanage, *vice* Arthur E. Durham, F.R.C.S., deceased.

Birth.

ROBERTS.—On July 6th, at Badlermere, Eastbourne, the wife of Astley C. Roberts, L.R.C.P. Lond., M.R.C.S. Eng., of a daughter.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

AUGUST 10, 1895.

The Bredin and Golding-Bird Prizes.

In a recent issue we drew attention to the fact that the Prize for Clinical Study, which lapsed last year, was about to be re-established. In another column particulars are given of the terms of the competition, which do not materially differ from those which regulated the Gurney Hoare Prize. We hope that Dr. Bredin may be rewarded for his generosity by hearing that his Prize has provoked a keen competition, and to that end we would remind candidates that while their reports need not be sent in till May 1st, 1896, they should be begun forthwith. The reports sent in would probably reach a higher standard of excellence and cost much less labour if they were put into the form in which they are to be presented while the patients who form the subject of them are still under observation in the Hospital.

The Golding-Bird Gold Medal and Scholarship will next be open to competition in March, 1896. We understand that the School authorities, exercising the power given them by the trust deed, have altered the subject for which the Prize is to be awarded. "The Methods of Diagnosis," though theoretically an excellent subject, has been found in practice rather difficult to manage from the examiners' point of view. Guy's has a very good record in the domain of Sanitary Science, and the choice of this very progressive branch of medical education as the future subject for the Prize should still further encourage its study amongst us.

It is said that the ease with which Guy's men fall into soft things in the way of private practice as soon as they are qualified makes the number who take the Diploma in Public Health comparatively small. Some, no doubt, have reason to regret afterwards that they have not thus qualified themselves to undertake the duties of Medical Officer of Health in the districts in which they are practising.

If one may read between the lines of the regulations for the competition for the Medal and Scholarship (which we print in another column), they have been drawn up with the view of encouraging more men to devote the necessary additional six months to work in the Laboratory by offering for competition amongst them a distinction which must be of great service to anyone who is applying for one of the more important Public Health appointments. We naturally hope that one of our own men will win the Medal, though by the terms of the competition it is open to men from other schools who join the Public Health course here.

The Successes at the London University.

The results of the recent London University Intermediate M.B. Examination are very gratifying so far as Guy's is concerned. It will be seen that our candidates have secured two Exhibitions and three Gold Medals, with Honours in every subject. Out of a total of 34 placed in Honours, Guy's occupies the premier position with 14 to her credit. We have thus secured half the Exhibitions and Gold Medals and six out of the ten First Class Honours. Mr. Charles Herbert Fagge is to be heartily congratulated in securing the Exhibition in Anatomy. This has not fallen to a Guy's man since 1882, when Mr. G. E. C. Anderson was successful, although four years later Dr. Parkin obtained the Gold Medal with marks qualifying for the Exhibition. Further, Guy's stands alone in Anatomy, and (with one exception) also in Materia Medica. Mr. Frederick Edward Walker, whose previous successes have been frequently commented upon in these pages, in addition to the Second Gold Medal in Anatomy, has gained First Class Honours in two other subjects. The winner of the Exhibition and Gold Medal in Materia Medica, Mr. Philip Turner, is also credited with a Second Class in Chemistry and a Third Class in Physiology. Mr. Fagge has also obtained a Third Class in Materia Medica. The other successful Guy's men have done well, and the record they have helped to obtain for their Hospital is one of which Guy's is justly proud. Mr. Fagge's success is especially gratifying from the fact that he matriculated after passing the Second Conjoint Examination—a step which has been more than justified by the results we announce with so much pleasure to-day. We may confidently predict a brilliant future for him and for his fellow Gold Medallists, Messrs. Walker and Turner, of whom we are equally proud. In connection with the Honours list in Organic Chemistry, we learn that all of those sent up from Guy's obtained Honours; one of the number, unfortunately, came down in Anatomy. To sum up, this year's Honours list is a very excellent one, and strikingly maintains the high place which Guy's has for many years taken at this Examination. Equally satisfactory are the results of the Preliminary Scientific Examination. Mr. Ernest Alfred Miller has taken Second Class Honours in Inorganic Chemistry, and there are five Guy's men in the first division of the entire examination, so that here also Guy's leads the way.

A Case of Double Pneumothorax.

CLINICAL LECTURE BY Dr. WASHBOURN.

The case to which I wish to draw your attention to-day is interesting both on account of the rarity of the disease and the mistake that was made in the diagnosis.

I shall first read you the report of the case:—

The patient was a boy, æt. 12, admitted to Clinical Ward under my care, on July 3rd, for urgent dyspnœa.

We could not get any reliable history, as the parents gave conflicting statements, but it seems probable, from the history we afterwards obtained, that the boy had been suffering from similar attacks at intervals for many years, but never of the same severity as the present one.

On July 1st patient was brought up to the front surgery suffering from dyspnœa. He was looking blue; but the inspiratory efforts were strong, and air was heard entering both lungs with a loud harsh noise. It was said then that he had been bad for two days, but that he became worse just previous to being brought up. The father has since said that the boy had often to leave off playing on account of attacks of breathlessness. Asthma was diagnosed and he was treated accordingly.

On July 3rd he was brought up to Out-patients, where I saw him. He was then suffering from an extreme attack of inspiratory dyspnœa, and was nearly moribund. I thought he was suffering from laryngeal obstruction, and urged instant admission. He was taken at once to John Ward, where tracheotomy was quickly performed. When placed on the table it was noticed that he made rapid inspiratory efforts with very little effect, and was collapsed. During the operation he stopped breathing, and artificial respiration was performed. Tracheotomy gave no relief to the dyspnœa, and the

accuracy of the diagnosis was doubted. The trachea below the wound freely admitted a feather which could be introduced to the commencement of the bronchi; thus showing that the non-entry of air was not due to an obstruction lower down in the trachea.

The impulse of the heart was seen in the substernal angle. On percussion, the left side of chest was highly hyper-resonant, and resonance on the right side was also increased. There was no cardiac dulness. Air could not be heard entering anywhere on left side and only feebly on right side. The liver dulness was much encroached upon, being only obtained near the costal margin. He was wrapped up in blankets and taken to bed as soon as artificial respiration could be safely discarded.

At 2.5 p.m. brandy ♏ x. was administered hypodermically, and at 2.30 p.m., Inj. Hypod. Liq. Strychninæ ♏ iv. was administered. As he was looking very blue, oxygen was administered with very good effect. His colour altered, and his breathing became easier though still rapid. In about an hour's time he became worse again, and oxygen had to be administered almost continuously. During the night, by occasionally administering oxygen and propping him up, he managed to get some sleep.

Next day, July 4th, he was better, the respirations being less frequent, and the oxygen had not to be administered so often. On examination, the resonance was the same as on the previous day. A little air could be heard entering left base, and some small moist râles could be heard. There was also some deficient entry of air on right side, and some whistling rhonchi. We now thought that there was a pneumothorax on left side and distention on right. What the cause was we could not ascertain; it was thought that it was most probably a ruptured phthisical vomica; we also discussed the possibility of the rupture of emphysematous bullæ, but we put it on one side on account of its rarity. The air gradually entered better on right side.

This improvement in condition of patient continued up to the morning of the 7th, when he had two very bad attacks of dyspnœa—one at 2 a.m. and one at 9.30 a.m.—and he died in a state of collapse at 12.45, the heart continuing to beat feebly for five minutes after respiration had ceased.

At the autopsy a double pneumothorax was found. The *left lung* was quite airless; there were old adhesions over both lobes and also between them. The large tubes contained muco-pus. There was general sacculated bronchiectasis, walls of spaces being smooth. *Right lung* was in same condition as left, but not quite so airless. There were many emphysematous blebs over the surfaces of both lungs.

I shall now give a brief resumé of the case. When I saw the boy at Out-patients he was suffering from very severe inspiratory dyspnœa. The supra-sternal space was sucked in during inspiration. Both sides of chest were resonant. There was deficient entry of air on both sides. There was no stridor. I diagnosed laryngeal obstruction, notwithstanding the absence of stridor; stridor being absent in the latest stages of laryngeal obstruction, when the patient is in a moribund condition, as this boy was. The serious state of the patient precluded a careful examination.

Tracheotomy was performed immediately after admission, without relief; therefore obstruction was somewhere below larynx. None was found in trachea; therefore it must be still lower down. On making a more thorough examination of chest it was found to be hyper-resonant on both sides, the left being more so than the right. There was no liver dulness and no cardiac dulness. There was no air entering left side, and but little entering right. Having regard to the fact that pneumothorax is almost invariably unilateral, we diagnosed pneumothorax on left side and compensatory distention on right side. This diagnosis fitted in with all the signs, explaining the hyper-resonances, the absence of liver and cardiac dulness, and the deficient breath sounds.

Patient began to improve, the air entering better on right side, and the liver dulness becoming more marked; so that we thought that the air was getting absorbed. There were no signs of fluid, though this is almost always present when air has been in the pleural cavity for any length of time. We could find no

definite cause for the pneumothorax. There was no history of any foreign body. We thought that phthisis was probably the cause, as it is by far the most common cause of pneumothorax. On the other hand, we discussed the possibility of the rupture of an emphysematous bleb, but put it on one side on account of its extreme rarity. At the autopsy it was quite clear that the cause was the rupture of one of the emphysematous blebs found covering the surface of the lungs.

We will now take the different points of the case in detail. In the first place, patient was suffering from dyspnœa. In order to decide what is the cause of dyspnœa, one must bear in mind the various possible causes.

I. First, we have *general conditions*—

1. *Anæmia*, in which the hæmoglobin is deficient in quantity, so that tissues cannot get a sufficient supply of oxygen.

2. *Urœmia*.—Dyspnœa is very often present in this condition.

3. *Diabetes*.—Dyspnœa is a very serious symptom in this disease, as it points to the advent of coma.

4. *Neurosis*.

These conditions can be easily diagnosed by the character of the dyspnœa. As there is no obstruction to entrance of air, the vesicular murmur is normal.

II. Next, *affections of the circulatory system* cause dyspnœa. One cause is *cardiac disease*, which causes dyspnœa by impeding the circulation of blood through the lungs. Another cause is *pulmonary embolism*, which comes on generally quite suddenly. In both these cases the air enters quite freely into the lungs, so that the vesicular murmur is normal. Further, in the case of cardiac disease there is nearly always a bruit, and in the case of the embolism some cause for embolism can be found—for example, pregnancy or typhoid fever.

III. *Diseases of respiratory system*.—The number of these diseases is very large, and for convenience we may divide them up according to the part they affect.

1. *Laryngeal obstruction*.—In these cases the dyspnœa is inspiratory, and there is stridor, which, however, may disappear in the late stages. There is generally a loss of voice, but it is not always lost—for example, in abductor paralysis of vocal cords. Another symptom is the sucking in of the supra-sternal and epigastric regions and the intercostal spaces. In such cases there is deficient entry of air into lungs, but a loud noise is heard on inspiration. In our case all these symptoms were present except the stridor, which, however, may be absent in a late stage. The most common cause of laryngeal obstruction, especially in children, is *diphtheria*. The fauces then are generally affected, and should always be examined. Another cause is *laryngeal tumour*, which may cause obstruction, either mechanically, by setting up spasm of larynx, or by causing inflammatory œdema of the larynx. Another cause is the *presence of a foreign body*, which may act in similar manner to tumour; but, as a rule, a foreign body passes quickly into one or other of the bronchi. *Laryngitis* and *abductor paralysis* also cause obstruction; the latter is caused by pressure on the vagus on one or both sides, or on its recurrent branch, or by some central nervous change, as in locomotor ataxy.

2. *Obstruction of trachea*.—In these cases the symptoms are the same as those in obstruction of larynx, excepting that there is generally but very little alteration in voice, and there is no up and down movement of the larynx. Obstruction of trachea is much rarer than that of larynx. It may be produced by pressure from inside or outside. The chief causes of pressure from without are an aneurysm of the aorta, enlargement of the thyroid gland, and mediastinal growth. The chief causes that produce obstruction inside are syphylitic stenosis and foreign body. As a rule, however, a foreign body passes on to either of the bronchi. When this has taken place, there is little or no entry of air on that side, while the other side is distended. A loud ronchus is also to be heard.

3. *Obstruction of bronchioles.*—This is caused by bronchitis and asthma. In bronchitis there are the various physical signs of this disease. In asthma the obstruction is caused by the spasmodic contraction of the small bronchial tubes.

In asthma the dyspnœa is *expiratory*, and loud rhonchi can be heard on expiration. Other causes of dyspnœa are :—

4. *Inflammation of the tissue of the lung.*—For example, acute tuberculosis, phthisis, pneumonia, emphysema. On examining the chest, the various physical signs which indicate the presence of each individual disease can be found. Another point to note is, that the dyspnœa in these cases is not as a rule so urgent as that due to obstruction.

5. Again, dyspnœa may be produced by *pressure on* the lungs by fluid or air in pleural cavity. If there is fluid present, it can be diagnosed by the characteristic physical signs which it gives.

Then, as to *pneumothorax* which was the cause in this case—

First, its *causes*. The most common cause of a pneumothorax is the rupture of a phthisical cavity. Another not infrequent cause is the rupture of an empyema into the lung. Another cause is direct injury to visceral pleura by a fractured rib. Other causes are gangrene of lung; and cancer of œsophagus, or of stomach, which might open into pleural cavity.

Another very rare cause is the rupture of emphysematous bullæ or of sacculated bronchietasis.

Next, the *diagnosis* of pneumothorax. Sometimes it is quite easy, at other times it is extremely difficult. The greatest difficulty is in phthisis, when a large number of adhesions exist, so that the pneumothorax may easily be mistaken for a cavity in the lung itself. Another difficulty is when it occurs on both sides, so that one has no normal resonance to compare with. But as a rule it is unilateral, and then it is easy to detect the hyper-resonance. Another important sign is deficient vesicular murmur due to the non-entry of air. But the breathing may be amphoric sometimes. Other signs are the bruit d'airain, *metallic sounds* and tinkling. The heart is displaced to the opposite side. *Secondary pleurisy* generally occurs, and after a time fluid collects in the chest.

The condition of the lung in our case was a rare one. As a result of whooping-cough or bronchitis, cylindrical dilatation of the bronchioles may ensue. This kind of bronchiectasis may be general, or confined to patches. When the cylindrical dilatation is confined to patches it may simulate a cavity, tubular breathing being heard over the patch, and the sputum being expectorated in large quantities at a time. Sacculated bronchiectasis is generally associated with emphysema and bronchitis, and does not give any special physical signs.

A rarer condition is a sacculated dilatation.

Hospital News.

In the Medical Wards.

Case under Dr. Pye-Smith.

Mary.

32. S. C., æt. 49. Admitted June 24th for discoloration of skin and weakness. Patient is a widow, and has had one child, who is alive and healthy.

Family history.—Patient's mother died from phthisis of fourteen brothers and sisters, only one is alive; the rest died when young from phthisis.

Personal medical history.—From birth up to fifteen years of age patient suffered from abscesses on her arms and breast, which would burst (leaving a scar); a fresh abscess would often form in the scar tissue. When ten years old she had rheumatism, and at twenty jaundice. Seventeen years ago she slipped when carrying a boiler and hurt her back; for three weeks after this she could not pass her urine, and a catheter was passed. Since this accident patient has difficulty at times on micturition, the urine then being high coloured and thick, but she has not noticed any blood. Menstruation began at fifteen, and up to the time of marriage was regular, but since then the periods have varied from six weeks to two months. Last summer she did not menstruate for five months.

History of present illness.—Six years ago patient had a sore throat, followed by considerable itching of the skin round the neck, which became deeply furrowed and brown in colour, afterwards black and rough. The skin round the groins, on the back, and in the axillæ next got black, furrowed and rough, followed by general pigmentation of the skin.

Condition on admission.—Temperature 98·6°; pulse 70; respiration 17. There is a yellowish-brown pigmentation of the skin.

Hands.—The right is dark brown in colour—on the dorsal aspect there are several little spots varying in colour from black to purple, not raised above the surface. The left is rather lighter in colour than the right—there are some small raised warty patches on the dorsum.

Wrists.—Both wrists are very dark and wrinkled by furrows, some running horizontally others vertically; there are a few dark spots on the right wrist, but none on the left.

Elbows.—The flexor surfaces of both elbows are darkly pigmented and furrowed. The left elbow is scarred and ankylosed.

Axillæ.—Both are deeply pigmented, the skin is hypertrophied and furrowed, causing ridges of skin which look like condylomatous masses.

Neck is black, and the skin much hypertrophied and divided by furrows into squares and diamond-shaped spaces. On the left side there are several large polypoid masses. There are warts under the chin.

The back is darkly pigmented and of a purplish tint, with many dark spots scattered about.

Circulatory system.—Normal.

Respiratory system.—Normal.

Alimentary system.—Liver felt half-inch below costal margin. Spleen not felt.

Urinary system.—Urine acid, 1020; albumin, ·5 per 1000; no blood; no sugar.

Treatment.—Full diet. Hot bath morning and evening, parts washed with soft soap and carbolic oil applied. The skin round the neck and in the axillæ is a little lighter than when patient came in.

Diagnosis.—Dr. Pye-Smith diagnosed Acanthodermia Nigricans, and remarked that there were only a few cases recorded.

Case under Dr. Hale White.

Stephen.

32. W. R., æt. 56. Admitted into Clinical April 30th; transferred to Stephen May 10th. Admitted for staggering gait and difficulty in speaking. Patient has been a sailor, has lived a rough life, and has been a heavy drinker. Has had malaria and ague, and syphilis, the latter fourteen years ago; well-marked secondaries. Six years ago patient had an attack similar to the present one; he was in Queen's Square Hospital for five months, and recovered completely; eighteen months later he had another slight attack. Present attack began early in April with a fit; patient was unconscious for two hours; this was followed by aphasia which lasted a week; his *right* arm and leg became weak, with occasional attacks of rigidity; he had numbness and shooting pains in his *left* arm and leg, and his gait became unsteady.

On admission.—Nervous system.—Mental faculties good.

Speech.—Defective from lip and tongue paresis. No aphasia.

Sight normal. No optic atrophy. No retinal changes.

Hearing.—Total deafness of left ear, with very distressing tinnitus; this condition came on gradually about a year ago.

Sensory symptoms.—Aching pain with numbness and a feeling of cold is present over the *left* side of the body, especially in the knee. There is localised headache in the left mastoid and occipital regions. Deficiency of sensation to touch, temperature and pain, all over the *left* side of the body (including the head, face and tongue); on the extensor surfaces of the forearm and leg the loss of sensation is nearly complete, elsewhere it is only partial.

Motor symptoms.—Marked weakness of the *right* arm and leg, of the *right* side of the tongue, and of the *left* facial muscles below the zygomatic arch.

Reflexes.—Patient is liable to sudden starts. Plantar reflexes greatly exaggerated; other superficial reflexes normal; knee-jerks very brisk. Patellar clonus. Fibrillary contractions of calf muscles; wrist and triceps jerks exaggerated.

Ataxy very marked in both arms and legs. Gait very jerky. Patient is apt to fall down, but he does not fall in any one direction.

Trophic changes.—General wasting; patient has lost two stone since Christmas; wasting greater in right arm and leg than in left. No wasting of tongue or facial muscles.

Other systems.—Slight bronchitis and emphysema. Lymphatic glands enlarged and hard. Node on sternum. Gumma beneath arch of right foot.

Progress.—Speech has become normal. Ataxy has markedly decreased, and patient can now walk fairly steadily and pick up things well. He is not now liable to sudden starts. The paresis of the right side of the tongue and of the left facial muscles has decreased. On the other hand, the weakness of the right arm and leg remains; the right leg continues to waste. The left hemianæsthesia is, if anything, more marked; and the tinnitus in the left ear is worse. Pain varies from time to time, but is, on the whole, better.

Dr. Hale White, in going over the case, said that the very intricacy of the case, and the multiplicity of the symptoms, showed that it must be due to cerebral syphilis; there was a diffuse patchy gummatous meningitis, with possibly some gummata growing into the brain; the localisation of the lesions was very obscure; a meningitis over the left motor area would account for the fit, the aphasia, the paresis of the right side of the tongue and the right arm and leg; the left facial paresis and the tinnitus might be due to pressure of a basal meningitis on the left facial and auditory nerves; the ataxy to meningitis over the middle lobe of the cerebellum; but even then the hemianæsthesia and the exaggerated reflexes still required explanation.

Treatment was rendered difficult on account of the ease with which patient showed symptoms of Iodism and Mercurialism. He was found to be far more tolerant

of the Green Iodide of Mercury (gr. i. in ferm. pil. t.d.s.) than of any other drug.

N.B.—Suggestions as to a possible distribution of meningitis and gummata, which will account for all the above symptoms, are invited.

In the Surgical Wards.

Cases under Mr. Davies-Colley.

Cornelius	7.	Fractured ribs and scalp wound.
	8.	Hip joint disease.
	16.	Cut throat. Fractured os calcis. Fractured olecranon. Scalp wound.
Luke	—.	Rodent ulcer. Enlarged prostate.
	12.	Chronic abscess in gluteal region.
	18.	Reducible inguinal hernia.
Lydia	3.	Tuberculous adenitis in neck.
	6.	Wound with rusty nail on heel. Abscess. Lymphangitis.
	23.	Cleft palate.
	Cot.	Double hare-lip.

Cases under Mr. Lucas.

Lydia	10.	Otorrhœa. Mastoid abscess. Sinus persisting.
	12.	Hydronephrosis resulting from moveable kidney. Nephrorrhaphy.
	14.	Enlarged glands in axilla (tubercular). Hydrops of knee.
Job	17.	Varicocele.
	24.	Ischio-rectal abscess.

Cases under Mr. Jacobson.

Accident	4.	Compound fracture of olecranon.
	7.	Compound comminuted fracture of lower jaw from horse-kick.
	13.	Fracture through upper third of tibia and fibula.
	29.	Fractured ribs and emphysema.
	32.	Fracture of bones of forearm. Admitted with gangrenous patch, the result of tight bandaging.
Naaman	1.	Recurrent sarcoma of glands of neck.
	6.	? Impacted extra-capsular fracture of neck of femur.
	8.	Sacro-iliac disease. Multiple abscesses.
	11.	Congenital hydrocele with imperfectly descended testicle.
	19.	Irreducible inguinal hernia.
	22.	Cleft palate.
Charity	9.	Spinal caries. Paraplegia.
	11.	Fractured jaw.
	18.	Recurrent sarcoma of kidney.
	19.	Tuberculous elbow joint.

Cases under Mr. Dunn.

Cornelius	4.	Longitudinal vertical fracture of os calcis.
	13.	Concussion. Hæmaturia.
	18.	Fractured femur; bones fragile, the results of long-standing paralysis.
Martha	3.	Hydronephrosis.
	17.	Malignant stricture of rectum.
	Cot.	Acute suppurative arthritis of hip-joint.
Lazarus	2.	Varicocele.
	3.	Large uric acid calculus in bladder; supra-pubic lithotomy.
	6.	Epithelioma of back of hand.
	16.	Otorrhœa. Mastoid abscess. Drowsiness. Antrectomy. Dura mater exposed and found to be inflamed.
	18.	Inguinal hernia, reducible.

The Arthur Durham Memorial.

It is proposed to raise a fund of £2,000 to endow in perpetuity two beds in memory of the late Mr. Arthur E. Durham. The following is the fourth list of subscriptions, and the collecting committee earnestly solicit the further help required to complete the fund. Subscriptions should be sent to Mr. C. H. Wells, at the Hospital.

	£	s.	d.
Amount previously acknowledged ...	1,420	8	0
Bacon, Sir Hickman, Bart., Gainsborough...	25	0	0
Ewart, J. H., Esq., Eastbourne	3	3	0
Odling, Professor, Oxford	3	3	0
Gayleard, C., Esq., Jamaica	3	3	0
Fawcett, J., Esq., M.D., Guy's Hospital ...	2	2	0
Shipman, G., Esq., Grantham	2	2	0
Adams, A. R., Esq., Guy's Hospital	2	2	0
Lamb, Master Clifford Heatherley, Ashton-on-Ribble	2	2	0
Colnogh, D. E., Esq., Ebury Street	2	0	0
Mutch, R. S., Esq., M.D., Brixton Hill ...	1	1	0
Salter, C. E., Esq., M.D., Scarborough ...	1	1	0
Collet, A. H., Esq., Worthing...	1	1	0
Wacher, F., Esq., Canterbury...	1	1	0
Wacher, S., Esq., F.R.C.S., Canterbury ...	1	1	0
Spurrell, W. D., Esq., Crondall	1	1	0
Palmer, C., Esq., Barton-under-Needwood ...	1	1	0
Vincent, H. E., Esq., M.D., Croydon ...	1	1	0
Morison, Margaret	1	1	0
Moss, E., Esq., M.D., Wrexham	1	1	0
Paradise, T. D., Esq., Kingston-on-Thames	1	1	0
Kingsford, E. C., Esq., Brondesbury... ...	1	1	0
Vicars, F., Esq., Brompton Crescent ...	1	1	0
Fagge, R. H., Esq., Leicester...	1	1	0
Cock, W., Esq., Peckham	1	1	0
Rae, A. J., Esq., Cheltenham...	1	1	0
Roper, A. L., Esq., M.B., Lewisham... ...	1	1	0
Wilkinson, J. C., Esq., Ashford	1	1	0
Farr, G. F., Esq., Kennington Road... ...	1	1	0
Wordley, A. W., Esq., Great Suffolk Street	1	1	0
Long, D. S., Esq., M.D., York	1	1	0
Swayne, F. G., Esq., Norwood	1	1	0
Muncaster, J. H., Esq., M.B., Halifax ...	1	1	0
Cregeen, J. N., Esq.	1	1	0
B. B. G.	1	1	0
Thomas, A., Esq., M.B., Aberystwyth ...	1	1	0
Cuff, R., Esq., M.D., Scarborough	1	1	0
Daniell, G. W., Esq., Blandford	1	1	0
Daniell, G. H. S., Esq., M.D., Blandford ...	1	1	0

	£	s.	d.
Howe, J. Duncan, Esq., Croston	1	1	0
Eccles, H. D., Esq., Midsomer Norton ...	0	10	6
Waller, W. A. E., Esq., Colonsay, Rugby ...	0	10	0
Per Miss Hickson—			
Hickson, Mrs. Chas.	3	3	0
Ducamp, Mrs. Roger	1	0	0
Ducamp, Roger, Esq.	1	0	0
Ducamp, Miss Mary	1	0	0
Per C. E. Carpmael, Esq.—			
Hewetson, H., Esq.	1	1	0
Howard, R., Esq.	1	1	0
Tyson, W., Esq.	1	1	0
Fagge, C. H., Esq.	0	10	6
Partridge, A. H., Esq., M.B.	0	10	6
Taylor, E. C., Esq., M.B.	0	10	6
Batchelor, S., Esq.	0	10	0
Per H. Millson, Esq.—			
Worthington, Miss	1	1	0
Chapman, —, Esq.	0	10	6
Per F. J. Steward, Esq.—			
Constable, J. C., Esq.	0	5	0
	£1,508	17	6

Suspension in Locomotor Ataxy.

There has been a case in John of a man suffering from severe gastric crises as a part of locomotor ataxy, which it has been found most difficult to relieve. He had attacks of great pain in the abdomen every day, accompanied by vomiting, and lasting five or six hours. Various drugs have been tried, but the only thing that really relieved him was morphia hypodermically; antipyrin, anti-febrine, and cannabis indica, with gastric sedatives were useless. These gastric attacks were all the man complained of; he had no ataxy. They completely disabled him, for he was doubled up with pain for several hours each day. Dr. Shaw suggested trying suspension; this has been done, and he is decidedly better since, whether as a coincidence or as a result. It seems worth while to give some notes taken from an article in the Medico-Chirurgical Transactions, vol. lxxiii., by Dr. Caquey. The method employed in this case has been using an ordinary Sayre's apparatus for plaster-jackets, keeping the man just resting on the ground, using both arm and head rests, for three to five minutes.

The first part of the article is devoted to the discussion of the question whether suspension causes elongation of the spinal column, and with the spinal column the cord, the nerve-roots and membranes. Caquey gives the result of most careful measurements before and during suspension, both on living and dead subjects; in the latter, dissections were made and the differences in measurements determined both along the spines of the vertebræ and along the front of the bodies of vertebræ. The facts lead him to disbelieve the ordinarily accepted theory for the way in which suspension exerts a curative effect—the theory that it is due to stretching of the cord, nerve-roots and membranes. His conclusions tabulated at the end of the article are, shortly:—

1. A considerable relaxation both of the cord and its nerve-roots occurs in suspension; the relaxation is greatest in the dorsal curve.

2. This effect is produced by the weight of the body alone; with muscular tension when the body is suspended from the axilla.

3. Relaxation of the cord in the neck is impossible, and cervico-occipital suspension is not only dangerous and unpleasant, but unscientific and inoperative.

4. Measures should be directed to the dorsal region alone. Therefore, where practicable, as in strong enough men, merely hanging by the arms from a bar above the head for a short time, is the best and easiest plan. In old and infirm men suspension from the axillæ alone is sufficient.

The case in Clinical has been suspended once a day.

Dr. Caquey has no doubt at all as to the efficacy of the treatment in some cases, for any of the troubles of locomotor ataxy. H. A. M.

Two Cases of Hydatid of the Liver.

We have lately had two cases of Hydatid of the Liver which may interest the readers of the Gazette:—

Case I.—Mrs. G., æt. 35. Under the care of Dr. Roberts. Last Christmas had pleurisy. She soon got better, but shortly afterwards noticed a lump in her right side.

On admission (March 7th).—A lump about the size of an orange could be felt in right hypochondrium. It seemed to be distinct from the liver, and occupied the position of the gall-bladder. It was not very tender. There was no history of colic, but patient said she had had a slight attack of jaundice.

On March 19th, an incision was made over the tumour, and the gall-bladder found to be quite healthy. The cyst was in the substance of the right lobe of the liver, near the anterior margin. It was opened and stitched to the abdominal wall. The cyst came away entire, and the patient made a perfect recovery, going out on May 15th.

Case II.—Mrs. S. Under the care of Mr. Couch. Admitted on March 28th for tumour in right hypochondrium. The tumour was first noticed last September, and has steadily increased since. It is tender and painful. The tumour occupies the position of the liver, and extends across the abdomen to left nipple line and downwards to within a couple of inches of umbilicus. It feels very hard and gives no suggestion of fluid. There is no thrill. An examination under an anæsthetic showed nothing further. An exploring needle was inserted into the tumour in left hypochondrium, opposite the tenth costal cartilage, and hydatid fluid drawn off.

On May 4th, Mr. Couch cut down on the tumour, making an incision just below tenth left rib. The cyst (which was a very large one) was stitched to abdominal

wall. Nearly half-a-gallon of fluid escaped. As much of the cyst wall was removed as possible.

Patient made a good recovery, but for a month lost a great quantity of bile through the wound. The motions were nearly white. She also had a well-marked erythema which itched very badly. The sinus left after the operation is now almost healed, and patient is in good health.

The case is interesting from the fact that although the cyst was so large, no evidence of its fluid nature was obtained till a needle was inserted. It was extremely hard and tender, and the most probable diagnosis seemed to be malignant disease of the liver.

Swansea. S. G. FLOYD.

Some Cases of Scurby.

(By kind permission of Dr. Lancaster.)

Four seamen came to Swansea Hospital for relief; they had just come from a four months' voyage on the Danish ship, "Clara."

They gave the following history. About five weeks ago, the ship's carpenter was taken ill, and since then the captain, mate, and five seamen (out of a crew of 16) were all taken ill in the same way.

They began by feeling weak and lazy, appetite failed, they vomited after food, and were very pale. Great dyspnœa on any exertion; swelling of calves, legs, thighs, arms, and forearms; pain in these parts on moving muscles.

They were given lime juice by the captain, and were a little better on arriving into port.

The carpenter, who was the worst, was admitted into the Hospital. Symptoms:—

1. *Brawny indurated swelling* of calves and thighs. Says his arms and breast have been similarly swollen.

2. *Œdema of feet* does not pit easily on pressure.

3. *Gums* quite normal. Says they have not been sore. (The captain has had red and swollen gums.)

4. *Petechiæ* on skin of legs.

5. *Pain* in calves and thighs.

6. *Hæmorrhage* absent in patient. (The captain has had epistaxis.)

7. *Complexion*, rather pale for a sailor.

8. *Eyes*, normal; no nyctalopia.

Respiratory, circulatory, and alimentary systems normal. Urine normal. Temperature normal.

The crew have had no fresh green vegetables for four months; water and rations good and plentiful. They have had on an average half a pound of potatoes each man per diem. It is not compulsory on Danish ships for the crew to take lime juice; there is plenty on board, and those who like can take it.

Treatment.—Lime juice, ℥j. t.d.s.
Green Vegetables.
Mist. Pot. Iodidi.

After one week of this treatment, they are now nearly well. The above cases are interesting in showing the mildness of the cases met with at the present time, and the difficulty of making a correct diagnosis.

C. G. BURTON.

A Case of Duodenal Ulcer.

W. H. T., a man of strong, robust frame, somewhat florid in face as a rule, æt. 66, came to me, complaining that he was getting thinner quickly. He was at this time engaged in no occupation, but had been a captain in the Merchant Service. This loss of weight had been going on for nine months, and was noticed by his friends. During this time he had not noticed anything else wrong in his health, but lately he had complained of a pain between his shoulders and in left side. This pain was not constant in position, being occasionally in epigastrium, sometimes between his shoulders or in left side, rarely in his right side. The pain did not come on after food, and there was no regularity in its oncoming, but it was often bad during the night, after several hours' sleep. The pain was described as "not very severe," a dull ache, often disappearing on rubbing the pit of the stomach. His tongue was a little foul, breath offensive, temperature normal; rather thirsty; bowels confined, excreta light in colour. He had been a very healthy man, and had few illnesses, dysentery in India many years back, and a few attacks of gout. The last attack occurred two years before present illness. Weight now 11 st. 13½ lb. Twelve months ago he said he weighed 14 stone.

On examining the chest and abdomen I could find nothing amiss. The bowels as a rule were regular, inclined to laxness. I prescribed for him, and told him to send a specimen of urine and come again in a few days. On examining the urine I found a small amount of albumin, sp. gr. 1012. On seeing my patient again I found that he was better, pain less, tongue clean, bowels more regular, but complained that "he had no appetite compared to what he was accustomed to." Being asked about urine passed, replied that "he had lately had to get up more often during the night and had passed more." I saw no more of my patient for a fortnight, as he stated he was better; but at the end of that time I was hurriedly sent for, and on arrival found him lying on his bed (about 8 p.m.), complaining of intense nausea, having vomited a large quantity of dark fluid mixed with undigested milk and a little blood. I was told that he had been sick once before (three days previous), but nothing was thought about it, or anything noticed in the vomit. He was in no pain at all. He was ordered a mixture of Bismuth and Hydrocyanic Acid, etc. In two hours' time he again vomited and brought up some bright blood, and was ordered morphia, ergot and bismuth. No more vomiting that night, and he appeared better next morning and had not lost his colour, and had been able to take some

milk and water; was in no pain. No vomiting during day.

At six a.m. the next morning, I was sent for. He had slept well during the first part of the night, but had vomited at two a.m. and brought up some blood, and again at five; the amount was not large altogether, but I found him blanched and restless, perspiring freely, complaining of nausea and sickness. As he complained of his mixture, I agreed to alter it; while writing the prescription, he again had an attack of hæmatemesis, was slightly convulsed and became unconscious, some of the blood being drawn into his larynx. While unconscious, the bowels acted largely, a large amount of clot and altered blood being passed.

Injections of morphia subcutaneously, ice to suck, and enemas of cold water for the thirst were given. The pulse gradually failed, and he died in the evening.

Post-mortem, 36 hours after death: strong muscular man, not looking his age; symptoms of muscular wasting; lungs healthy; kidneys granular; stomach large, but healthy. A tumour the size of a small hen's egg was to be felt just below the pyloric end of the stomach. This proved to be the head of the pancreas, indurated. A large ulcer was to be seen in the vertical part of the duodenum, which had eroded the superior pancreatico-duodenal artery. The ulcer was circular, sharply cut out, and had evidently tried to cicatrise in parts; there were two openings into the artery, one very small, the other a large jagged slit. The floor of the ulcer was formed by the head of the pancreas.

This case seems to illustrate the difficulty of diagnosing these duodenal ulcers; in spite of its being perfectly typical. The ulcer must have been there some considerable time, giving rise to these definite (but difficult to localise) pains.

Drs. Shaw and Perry quote in Guy's Hospital Reports, 1893, twelve cases of Bright's disease and duodenal ulcer. (No ulceration of any sort in the intestines.)

Badlesmere, Eastbourne. ASTLEY ROBERTS.

Guy's Hospital Dental Department.

PRACTICE DURING JUNE, 1895.

Gold Fillings	458
Plastics	589
Artificial Crowns	71
Dentures	13
Devitalized Teeth	161
Scalings	75
Regulations	7
Attendance for Extractions under Anæsthetics ...	464
,, ,, without ,, ...	510
Total	2348

AT A CHILDREN'S HOSPITAL.—Little boy, to little girl, who has just addressed a female clinical clerk as "lady": "Go on, Alice, what are yer talkin' about? That ain't a lady; that's a lady-doctor."

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

C. P. C., WEST KENSINGTON.—No tubercle bacilli could be found in the sputum.

T. & W., HACKNEY.—The preparation contains a small scirrhus carcinoma embedded in much fatty breast tissue at the periphery of the gland. There are no enlarged glands in the fat, and no visible lymphatic deposits on the deep surface of the breast. Nipple not retracted.

T. W. L., WOOLWICH.—Tubercle bacilli are present in the sputum, but only in small numbers.

F. W. L., ILFRACOMBE.—The structures sent are separated cells from the pulp of a lemon or orange.

H. L. E. W., SALISBURY.—Bacilli anthracis are present in the serum surrounding the pustule.

G. F. D., TYLDESLEY.—No tubercle bacilli could be detected in the specimen of sputum.

R. J. R., LOWESTOFT.—A blood serum tube was planted from the membrane, and, after 24 hours' incubation, a good growth of small, raised, whitish colonies had made their appearance, which microscopically proved to consist of Klebs-Löffler bacilli in a pure culture.

J. M. B., BURGESS HILL.—*Morning*—Reaction acid, spec. gr. 1018; albumin, blood and sugar absent. Microscopical examination of the deposit showed the presence of crystals of calcium oxalate, and the stellar phosphates. There was also a fair quantity of squamous epithelial cells and granular leucocytes. No tube casts could be found. The only point of importance in the specimen is the slight excess of granular leucocytes over normal. *Night*—Reaction acid, spec. gr. 1020; albumin and sugar absent. Microscopic examination of the deposit failed to reveal the presence of renal tube casts. A few red blood discs were seen, also crystals of urate of ammonium and oxalates of lime.

PATHOLOGIST.

Passim.

In our issue of June 8th last, we noted, with regard to the report of the Medical Officer of Health on the Sanitary Condition of the Parish of St. George's, Southwark, that the Vestry Delegates had been before the L.C.C. to urge the immediate necessity of demolishing the unsanitary area known as "Falcon Court."

We rejoice to learn that the L.C.C., at a recent sitting, passed a resolution to the effect that the area in question should be cleared, after a piece of land had been purchased by the Council, whereon to re-house one half of the inhabitants displaced. This scheme has been persistently pressed upon the notice of the Vestry and County Council by the Medical Officer of Health for the past two years, and we may confidently expect that some practical steps will soon follow the "resolution."

The value of this space as a lung for this over-populated district cannot be too strongly insisted upon, and we wish Dr. Waldo every success in the energetic steps he is taking in this direction. If we consider that these noisome and stinking districts of Southwark, with their degraded inhabitants, are in the closest proximity to the centre of the wealth and intelligence of London, it should be admitted that they are a standing disgrace, both to civilisation and humanity.

The Sanitary Institute announce a series of Lectures to be given at the Parke's Museum, Margaret Street, W., during next Winter Session. These lectures have been arranged for the special instruction of those desirous of obtaining knowledge in sanitary requirements and regulations. The Museum and Library will be open free during September, October, and November to Students attending the Course. Further particulars may be obtained of E. White Wallis, Secretary.

"A Pertinent Enquirer" would like to know who is responsible for the arrangement of the Guy's colours as displayed by ties and the ribbons worn on straw hats. We are quite unable to inform him. We can only say that the "Blues" Committee of the Clubs' Union rule the "Blues," and we should ourselves like to see some definite arrangement finally settled upon with regard to the disposition of Guy's colours.

The Swimming Club is this year in a very flourishing condition, and we hear that the St. Saviour's Baths are largely patronised by our Members. This is as it should be, and we hope therefore that the Clubs' Union will see their way to favourably receive the application the Club is intending to make for amalgamation to the Union. Apart from the fact of its activity and usefulness, the Club is in a fine position financially, and has never become an "expensive" constituent institution. Now that the Club has ended a brilliant season by magnificent victories in the Hospital Polo Cup Ties, its inclusion in the Clubs' Union is practically assured.

A House Dinner of the Students' Club will be held on October 1st next, on the occasion of the opening meeting of the Pupils' Physical Society.

We are requested to call the attention of those gentlemen who intend to dissect during the coming Winter Session, to the very useful little book containing the Rules of the Dissecting Room (and other valuable information), which may be obtained from the Medical School Office.

The Editor has left the following for his readers to deal with:—

S A Y
E M O
R I P
R O K
C O F

The Bredin Prize for Clinical Study.

This Prize, of the annual value of £25, is given by Dr. Richard Bredin, a former Student of Guy's Hospital, with the object of encouraging accurate clinical observation.

It is awarded to the Student who submits the best reports of three Medical and three Surgical cases, with a commentary upon each case.

The reports must be presented to the Dean on or before the first day of May, and the cases recorded must have been in Guy's Hospital during some period of the Candidate's studentship.

Each report must be the Candidate's own work, and must comprise a minute description of the clinical phenomena, full and minute details of the morbid changes, and remarks on the therapeutics of the case.

The report must not be headed with the name of the Candidate, but must have some motto or *nom de plume* prefixed, and must be accompanied by a sealed envelope with the same motto or *nom de plume* on the outside, which envelope is to enclose a card having the name of the Candidate written upon it.

Golding-Bird Gold Medal & Scholarship

THIS Prize was founded by the late Mrs. Golding-Bird in memory of her husband, Dr. Golding-Bird, F.R.S., Assistant Physician to this Hospital, 1843–54. It consists of a Gold Medal of the value of £13, and a sum of money of about £20.

The next examination for this prize will be held in March, 1896, and will be open to any Student of the Hospital who has spent the preceding Winter Session at the Medical School and who did not possess a registrable qualification to practice medicine before Jan. 1st, 1894.

Subject of the Examination.—Sanitary Science including Bacteriology, Chemistry and Physics, so far as these bear upon the prevention of disease.

Students who follow the Laboratory Course of the Public Health Department, beginning in October next, will, if otherwise eligible, be entitled to compete for this prize in March, 1896.

Cases for Clinical.

I. E. M., æt. 5. Admitted July 22nd for dyspnœa, due to laryngeal obstruction, with history of pain and soreness. Temperature 97·4°; pulse good. Entry of air bad; no membrane visible on tonsils, pharynx, palate or uvula; some discharge from the nose. The cervical glands much enlarged on both sides. Tracheotomy performed, and 15cc. of antitoxin injected in the loin on completion of the operation. Cultivations taken on blood serum from nose, fauces and larynx during the operation.

23rd. Patient much better. Knee-jerks present; no physical signs in chest. Takes food well. 10cc. of antitoxin again injected at 10 p.m. Klebs-Löffler bacilli found in the cultivations.

24th. Trace of albumin in the urine. Tube was removed for short time to-day. Some membrane coughed up, but breathing very bad, so tube re-inserted.

25th. 10cc. antitoxin again injected at 10 p.m. No broncho-pneumonia.

26th. Tube taken out permanently. Pulse is weak and rather rapid, and somewhat irregular.

28th.—No change; child seems very well; pulse is not much improved. She is having strychnine and iron.

After each injection of antitoxin there was a slight temporary rise of temperature. Thus, after the first injection, temperature rose from 97·4 to 101°; after the second, from 98·4 to 99·4°; and after the third, from 98° to 99·2°. As yet no rash has appeared, and no paralysis has declared itself, unless the condition of the pulse be considered as due to some paresis of the myocardium. Her knee-jerks have remained brisk throughout.

30th. No albuminuria. Pulse good.

August 2nd. To-day, on the legs a morbilliform rash, which did not involve the chest. It spread over the face from below upwards; scarcely any on the forehead. No rise of temperature, no coryza, and patient appeared quite well.

3rd. Rash has nearly gone. Tracheotomy wound has healed up.

9th. Child is quite well.

The British Medical Association.

THE Sixty-third Annual Meeting passed off last week in a highly satisfactory manner. Addresses on Medicine, Surgery, Ethics, Pathology, Hygiene, etc., of more or less interest to members, have been delivered by eminent medical men, and the occasion has been marked by a more than usually interesting number of papers read before the Association. In addition to the discussions which these papers have demanded, close attention has been given to subjects embracing the more personal interests of medical practitioners. We refer particularly to the debate on the Registration of Midwives, and also to that on Medical Defence. The discussion on the former subject especially "raised the wind," and some of the speakers occasioned no little excitement. We ourselves by no means intend to discuss the merits or demerits of the Registration of Midwives: the question remains still an open one. However, by the adoption of Mr. Lawson Tait's amendment, the Association, which must be taken as representative of the whole medical profession, has spoken; it remains to be seen if it has spoken to effect.

The resolution moved by Dr. Arthur Wellsford—"That it is to the interest of the public and of the medical profession that the Council of the British Medical Association should take power and authority to protect both individual and collective interests of the medical profession, and that the Council is requested to take such steps as may be necessary to enable them to actively undertake these duties and to devote a portion of the income and funds of the Association for these purposes"—was carried by a large majority.

In addition to the consideration of these and allied subjects, the visit of the British Medical Association to the Metropolis has been made the occasion for almost endless exhibitions to places of interest and entertainment, and has given full scope to the extension of hospitality in every direction. To give a detailed account of these functions is hardly within our compass; we must refer our readers for this to the *British Medical Journal*. One pleasant feature of the week has been the manner in which the Metropolitan Medical Schools have, almost without exception, invited the members of the Association to visit, either with luncheon or without, the wards and buildings of their own hospitals. A general invitation was given to the Association to visit Guy's Hospital on August 2nd—an invitation of which some two hundred visitors took advantage. Dr. Washbourn was mainly responsible for the arrangements which, in spite of bad weather, were excellent, and were carried out most successfully. It was perhaps a little unfortunate that no arrangements had been made to "receive" lady visitors not interested in things medical; however, thanks to the kindness of the matron, parties were escorted over the laundry and the hostel, the kitchen and other places stronger of appeal to the feminine eye than the wards and laboratories. The whole of the

hospital buildings were open for inspection—the wards, the College, the exhibition room, the Eye Wards, the Operating Theatre and the Dental Department being specially favoured. Refreshments were admirably served in the Court Room and in the College throughout the afternoon from 3 to 6. In the wards the physicians and surgeons showed the more interesting cases; in the Eye wards Mr. Higgens operated for cataract; in the Operating Theatre Mr. Lucas for hydronephosis and for malignant disease of the breast; in the Dental Department a clinical demonstration on operative dental surgery was given, while old "Mary" was utilised as an exhibition room. Here there was a display of surgical instruments by Messrs. Down Bros., and a most beautiful collection of drawings, arranged by Dr. Bryant, "which came as a great surprise" to most of us. They were much admired and we hope the suggestion that was made to us of using old "Mary" as a permanent gallery for this valuable collection will take practical shape. In addition to the drawings and instruments shown in this same wing, Mr. Peters showed some cultures and microscopical specimens of both the true and the false diphtheria bacillus.

The following beautiful specimens, shown by the Surgical Registrar, Mr. G. B. Smith, received appreciative attention.

Adeno-Sarcoma of Testis, showing glandular structure in a myxo-sarcomatous matrix. A few small masses of cartilage.

Carcinoma of Testis, showing large masses of epithelial cells, having in many places a central clear lumen, small cystic spaces lined with a single layer of cubical epithelium; a small patch of cartilage. (Adeno-carcinoma.)

Malignant Parotid Growth. This shows the irregular branching clumps of epithelial-looking cells, similar to those seen in simple parotid tumours, the origin of which is doubtful. The matrix is myxo-sarcomatous. In places the section is crowded with oval sarcoma cells with less myxomatous tissue.

Adenoma of Thyroid. Three sections showing the varying structure met with. In one, solid strings of cells with inter-cellular, colloid-looking material. In another, small, round, solid clumps of cells, and but slightly dilated alveolar spaces, with some amount of inter-alveolar colloid material. Another specimen showed dilated alveolar spaces with no inter-alveolar deposit.

Exophthalmic Goitre. The spaces lined with cubical and columnal epithelium, with inter-alveolar projections.

Small Growth from Skin, consisting of small, round cells arranged very regularly in rows round vascular spaces. (Angeio-sarcoma). The matrix was structureless.

Growths from Skin, having adenomatous structure, and appearing to originate in the sweat glands; proliferation of the epithelial cells occurring in some of the growths (? malignant growth).

Post-Rectal Dermoid, lined with an epithelium resembling that of the intestine. (Shown by Mr. Golding-Bird at the Pathological Society, 1894).

Rodent Ulcer.

Myeloid Sarcoma from Tendon Sheath.

Hæmo-lymphangeioma, the so-called degenerating nævus removed from posterior border of axilla.

Proliferous Cystic Tumour from Breast, lined with columnal epithelium. (Duct cysts).

Melanotic Alveolar Sarcoma from skin, showing well-marked alveolar arrangement of cells.

Adenomatous Tumour of Upper Lip.

Smoker's Patch. Localised chronic superficial glossitis at tip of tongue.

In the other wing were exhibited some very interesting cases, for the collection of which we were chiefly indebted to Drs. Washbourn, Pitt and Bryant. Amongst the cases of nervous diseases were Friedreich's disease, locomotor ataxy, with absent Argyl Robertson pupil, supposed cause traumatism, paralysis agitans,—one sided; hemiplegia with third nerve paralysis, syringomyelia and others. There was also a good example of a sporadic cretin, and an array of cases of skin diseases. These latter included instances of general psoriasis benefited by tar ointment and arsenic, acne, alopecia areata, herpes zoster, along lower intercostal space, lichen, lupus erythematosus.

Considerable interest was manifested in a case of fractured tibia, which had been successfully united by a steel screw, and in several cases from the Eye ward.

Mr. J. Eyre showed these last cases, which included examples of gummatous iritis, rheumatic iritis, suppurating phlyctenule and cataract, ? congenital.

Mr. Pakes exhibited cultivations of moulds of the micro-organisms of anthrax, typhoid, coli, diphtheria, and cholera, and the formic aldehyde apparatus for fixing.

There were also exhibited some of the most interesting pathological specimens to be found in our museums. Among these were specimens showing biliary obstruction, calcified gall-bladder, biliary fistula, pappilliferous cyst of common bile duct, impacted gallstones and others removed by operation, actinomycosis of lung and liver, Madura disease of foot, distended gall-bladder in enteric fever, carcinoma of gall-bladder, separated epiphysis of radius, hydatid of tibia and spine, pappillomata from larynx, epithelioma from larynx, tubercular ulceration of tongue, enterectomy, gastro-jejunostomy, sutured intestine for punctured wound of the ileum, enterectomy with artificial anus, vermiform appendix after removal, and five showing congenital heart.

Altogether, the afternoon passed off most satisfactorily, the students for the most part performing the part of hosts with good zest. Some of us thought more might have been expected from Guy's as one of the leading schools, but if there was anything lacking in the *quantity*, there was no question as to the excellent quality of the fare provided for our guests last Friday week.

Vacant Dental Appointment.

Applications are invited for the post of Demonstrator of Practical Dentistry, and should be sent to the Treasurer, at the Counting House, not later than Saturday, August 31st. Particulars of the duties and remuneration may be obtained on application to the Dean.

Royal National Pension Fund for Nurses.

ON Friday, the 26th ultimo, Her Royal Highness the Princess of Wales, President of this Fund, received at Marlborough House a large number of its new members, to whom she gave their certificate of membership. In the morning there was a preliminary meeting in the Queen's Hall, Langham Place, where the nurses were instructed as to the positions they were to take, and had their invitations for the afternoon handed to them. The scene was a striking one. The whole of the floor had been cleared of chairs, and here, in eight sections, the nurses assembled, the various colours of their dresses, with their white aprons and caps, forming a pleasing picture. There were nurses from nearly all the London hospitals, Guy's sending a particularly large contingent, while some came from various parts of the country, notably Derby and Northampton. The nurses having passed in order before Mrs. W. H. Burns, who handed to each her invitation for the afternoon, the band of the Royal Artillery, under Cavaliere Zavertal, meanwhile playing a selection of music. Mr. Burdett moved a vote of thanks to Mrs. Burns, which was carried by acclamation.

At the ceremony at Marlborough House, the Prince and Princess of Wales were accompanied by their Royal Highnesses the Duchess of Fife, Princess Maud, Princess Victoria, the Duke of York, and the Crown Prince of Denmark. Amongst those present were Lord and Lady Rothschild, Lord and Lady Suffield, Mrs. J. Pierpoint Morgan, Mr. and Mrs. W. H. Burns, Mr. Walter Burns, junr., Miss Burns, Sir W. and Miss Broadbent, Mr. Thomas and Miss Bryant, Mrs. and the Misses Burdett, Dr. Hubert, Mrs. J. S. Bristowe, Mr. Herbert C. Gibbs, Mr. George Norman, Mr. and Mrs. Rawlings, Mr. George King, and the matrons of the following hospitals:—St. Thomas's, Guy's, Charing Cross, the Leeds General Infirmary, Royal Infirmary, Derby, Lewisham Infimary, Miss Peter, of the Queen's Jubilee Nurses, and others.

The nurses awaited the appearance of the Princess of Wales on the lawn, where they had been arranged four abreast in long columns. Each wore on her left arm a badge instituted by Her Royal Highness to designate the relation she bears to them, and show its personal nature. It consists of an armlet of red ribbon bordered with white, fastened under a lozenge on which Her Royal Highness's monogram and coronet are embroidered. Red and white are chosen as being the Danish national colours, thus linking the land of the Princess's birth with that of her adoption. The certificates are specially designed, and bear—besides the *fac-simile* autograph of the Royal President—the figure of an angel with outstretched wings, appropriately entitled "Sympathy." After the certificates had been delivered,

The PRINCE OF WALES delivered the following address—Nurses,—It affords the Princess and myself much pleasure to receive you here to-day as the representatives of the third and fourth thousand who have joined the Royal National Pension Fund for Nurses. I understand that you come from all parts of England, Ireland, Scotland, and Wales. I am speaking not only as the Patron of the Fund but on behalf of the Princess, your President, who has, from its conception, taken the greatest personal interest in the progress of this beneficent Society. She has charged me to say how delighted she is to receive you here to-day, and how much she hopes that the armlet in the Danish colours, suggested by herself in order to attach every nurse member of this Fund directly to her person, will serve to remind each member who wears it, when she goes back to her work of ministering to the requirements and needs of the sick in any part of the British Empire, that the thoughts of the Princess are with every member of the Fund, and she hopes that this knowledge may increase their self-respect and stimulate them to greater exertions in the noble work to which they are devoting their lives.

Three hearty cheers were then given by the nurses for their Royal Highnesses the Prince and Princess of Wales.

Mr. WALTER H. BURNS, the Chairman of the Council, then made a brief speech, and at its conclusion, refreshments were served in a tent on the lawn, and their Royal Highnesses gratified the nurses by speaking to many of them individually.

The enjoyment which the nurses felt at the Princess of Wales's gracious treatment of them was clearly evident, and the consciousness of her interest in them and their work will doubtless sustain them in after days.

(From the *Morning Post.*)

Humours of Medicine.

THE following few incidents in General Practice I thought might interest some of the readers of GUY'S HOSPITAL GAZETTE.

Some strange sayings of peculiar people: I only quote four, two aspiring from children and two from adults. "Age before honesty," though I can confidently affirm for the absolute honesty of all.

1. A little girl living in the house of a medical man came to me in my surgery one day and asked me to give her "an antipyrine for Miss L——." I straightway proceeded to weigh out the necessary powder, knowing the young lady frequently derived great benefit from a small dose of this remedy. While so occupied, the girl (æt. 9) asked in a quaint and naturally childish way, "I wonder, doctor, why they don't have an uncle pyrine?"

2. A little boy, aged 6, told me, when calling on my morning round at a house near by where a sudden death had occurred, that he knew where there was a "dead un," to which I replied I knew where there were lots of "dead uns," but was not prepared for his questioning reply, which was "Did *you* dead 'em?"

3. A woman suffering from cervical endometritis, naturally enough suspected she was really suffering from carcinoma (I say naturally enough, because if the kidney is said to be the neurotic organ of man, I am sure the uterus is in a woman), and expressed the horror she felt of such a thing by referring to what kind friends had told her, and she then told me of a friend of her's who had had "the whole of her inside taken away and then wasn't cured."

4. Another woman came to me wishing to be treated for constipation, but thought it only due to me to explain that she had undergone a serious operation. Not liking to divulge the nature of the operation too suddenly to a rather young Medico—at least I took this to be her idea—she merely gave me to understand it was an "internal operation" she had undergone. "Indeed," I answered, "I suppose you could not tell me the exact nature of the operation, could you?" "Oh, yes," she answered; "I had my 'over-alls' removed." I am proud to add, for the honour of Guy's training, I kept my countenance—till she left the room.

B. G. R.

Nursing News.

On Saturday, July 20th, the "Society of Masseuses" presented Certificates to those who had successfully passed the Society's examination in the Theory and Practice of Massage. Sixteen certificates were gained, and we are glad to say that the two candidates from Guy's—Nurse A. Moor and Probationer M. Davidson—were among the successful ones.

By the retirement of Miss Willes (Sister Cornelius), not only the Nursing Staff, but also the Hospital, sustains a distinct loss. Miss Willes, who has worked at Guy's Hospital for a considerable number of years, left on the 30th ultimo. Miss Dupuis has been appointed to succeed her.

Nurses O'Donnell and Langley, of Guy's Institution, have successfully passed the examination of the L. O. Society. They trained in the Guy's Lying-in Charity under Nurse Ashford.

The following Members of Guy's Hospital Nursing Staff were entitled, as Members of the Royal National Pension Fund for Nurses, to be present to receive certificates, on the occasion of the distribution by Her Royal Highness the Princess of Wales:—

The Matron.	Nurse Blake.
Assistant Matron.	" Naters.
Sister Philip.	" Halstead.
" Martha.	" Ord.
" Accident.	" Sully.
" Lazarus.	" Nutt.
Nurse Phyllis Phillips.	" Trail.
" Stevens.	Miss Evans.
" Pritchard.	" Hughes.
" Palmer.	" Upham.
Nurse Oding.	Nurse Rawlings.
" Pearce.	" Wooll.
" Lyons.	" Baker.
" Owen.	" Manning.
" James.	" Robins.
" Poole.	" Price.
" Silverwood.	" Hawkins.
" Vicary.	" Wilkinson.
" Chester.	" Rees.
" Saunders.	" Bidwell.
" Langley.	" Joy.
" Hackett.	" Sleap.

Nurse Hayward.

Guy's Hospital Dental Society.

The First Annual General Meeting of the Society was held on Tuesday, May 21st, Mr. Maggs in the chair. The Hon. Secretary read his report in which he stated that the society had passed through its first season in a highly satisfactory manner, the total number of members being no less than 101; he gave a summary of the season and mentioned that arrangements were being made with the Guy's Hospital Gazette Committee to publish the society's transactions in the Gazette, also that they were indebted to the Dental Council for their liberality in paying the annual premiums for the insurance against fire of the members' instruments.

The Hon. Treasurer next read the balance sheet (appended), and both the report and balance sheet were unanimously adopted.

It was unanimously resolved to apply to the Council of the Clubs' Union for affiliation to the Union.

The following officers were elected for the ensuing year, 1895-96: President, W. A. Maggs, Esq., L.R.C.P., M.R.C.S., L.D.S. Vice-Presidents: F. Newland-Pedley, Esq., F.R.C.S., L.D.S., J. H. Badcock, Esq., L.R.C.P., M.R.C.S., L.D.S., H L. Pillin, Esq., L.D.S. Hon. Treasurer: M. F. Hopson, Esq., L.D.S. Hon. Secretary: A. DeMierre. Committee: C. H. Wilson, K. W. Goadby, E. Bascombe, J. L. Payne, U. E. Cave.

A vote of thanks to the retiring officers and to the Chairman was then passed, after which the meeting was adjourned.

An extraordinary general meeting was held on July 5th, Mr. Maggs in the chair.

The Hon. Secretary read a letter from the Council of the Clubs' Union, announcing the decision of the Union to admit the society as a constituent institution.

It having been found necessary to alter a few of the rules, after a discussion, some alterations were agreed upon.

It was unanimously resolved to accept the offer of the Gazette Committee to publish the society's transactions in the Gazette.

A vote of thanks to the president concluded the meeting.

BALANCE SHEET.

Receipts.	£	s.	d.
From the Staff	12	10	0
From Past Students	3	10	0
From Present Students	9	2	6
	£25	2	6

Expenditure.	£	s.	d.
Printing Transactions, Rules, etc.	17	17	9
Steward of Club for Teas	3	6	9
Secretarial Expenses, Postage and Stationery	1	17	5
Balance in hands of Treasurer	2	0	7
	£25	2	6

MONTAGUE F. HOPSON, Hon. Treasurer.

Audited and found correct,

F. C. BEAUMONT, A. DE MIERRE, } Auditors.

Notes from the Dispensary.

Turkey Rhubarb.—The official Radix Rhei is popularly known as Turkey Rhubarb. The name originated from the trade route by which the drug formerly came into Europe. Medicinal rhubarb is produced in the northern provinces of the Chinese empire, a part of the world so little known to Europeans that the botanical source of the plant is still uncertain, for no competent observer has ever ascertained the species of rheum which affords the commercial rhubarb. The two species, R. Officinale and R. Palmatum, which are given as sources of rhubarb do not, however, produce a root agreeing with the Chinese variety. Rhubarb has a very ancient history. The Chinese were acquainted with its properties long before the Christian era. The Emperor Shen-nung, the father of Chinese agriculture, who reigned 2700 years B.C., wrote a treatise on rhubarb. In Western Asia and Europe, the root is mentioned by Dioscorides, Pliny, and Celsus, and about the middle of the 7th century it occurs in the writings of Benedictus Crispus, Archbishop of Milan. Among the Arabian writers on medicine Mesne, (in the early part of the 11th century,) mentions the rhubarb of China. The famous Venetian traveller (Marco Polo) was the first, and almost the only, European who has visited the rhubarb-yielding countries of China. Rhubarb in the 12th century was imported from India, and shipped from Syria. Vasco de Gama mentions it in 1497 among the exports of Alexandria. In fact, the drug was carried from the Far East to Persia, whence it was brought by caravan to Aleppo, Tripoli, Alexandria, and even Smyrna. From these Levant ports it reached Europe, and was distributed as *Turkey Rhubarb*. The Levant rhubarb gradually disappeared from commerce, and that coming through Russia not only took its place but likewise its name, until the term Turkey Rhubarb came to be the accepted designation of the drug imported from Russia. The Russians appear to have subjected rhubarb to a special control as early as 1687, and to have monopolised the whole trade about 1704. Caravans, fitted out by the Crown, alone brought the drug to Moscow until 1762, when the caravan trade was thrown open. This overland rhubarb trade has been destroyed by the opening of the Chinese ports to commerce, so that the root has ceased to be sent through Russia, and at the present day the European market is supplied with rhubarb from the provinces of Shensi, Kansu and Szechnen. It is taken from these provinces to Hankow, on the upper Yangtze, from whence it is sent down to Shanghai, and there shipped to Europe. Turkey rhubarb has now become a thing of the past: it can only be found in museum collections.

Resorcin a Test for Albumin in Urine.—The re-agents employed up to the present for the detection of albumin in urine are acids or substances which precipitate albumin only in the presence of acid, so that in urines rich in urates there is frequently a precipitate of uric acid, and this may be mistaken for albumin. Nitric acid, which is the re-agent in ordinary use, is particularly liable to errors of this description. Resorcin (Metadioxybenzolum) possesses the power of coagulating albumin, and in a watery solution containing a third of its weight it forms an exceedingly delicate test for albumin in urine. In this respect it is superior to nitric acid, for where the quantity of albumin is so small that no indication is given by it, Resorcin will produce a slight cloud. When the solution of Resorcin is added to the albuminous urine so as to form a layer, it immediately produces a very distinct white ring at the separation of the two liquids. Urates or urea do not give a ring, nor alkaloids, unless in very concentrated solutions, which is never the case in urine. Resorcin precipitates peptones. If there be reason to believe that peptones are present, in order to distinguish it is only necessary to put the tube into boiling water for a few minutes. If the ring be due to peptones, it will disappear; to albumin, it will remain.

H. COLLIER.

Pass List.

University of London, July, 1895.

INTERMEDIATE EXAMINATION IN MEDICINE.

EXAMINATION FOR HONOURS.

Anatomy.

First Class.

Fagge, C. H., obtained the Exhibition and Gold Medal.

Walker, F. E., obtained the Gold Medal.

Physiology and Histology.

First Class.

Walker, F. E.

Second Class.

Richmond, G. E.

Third Class.

Turner, P.

Organic Chemistry.

Second Class.

Milton, W. T. Richmond, G. E.
Turner, P.

Third Class.

Bruce, H. W.

Materia Medica and Pharmaceutical Chemistry.

First Class.

Turner, P., obtained the Exhibition and Gold Medal.
Milton, W. T. Walker, F. E.

Third Class.

Bruce, H. W. Fagge, C. H.

PASS LIST.

Entire Examination.

Second Division.

Berry, T. P. Cleveland, A. J.
Telling, W. H. M.

Excluding Physiology.

Second Division.

Handson, L. E. C.

Physiology only.

Second Division.

East, W. N. Hall, E. S.
Moore, P. W.

INTERMEDIATE EXAMINATION IN SCIENCE.

EXAMINATION FOR HONOURS.

Inorganic Chemistry.

Second Class.

Miller, E. A.

Honours Candidates Recommended for a Pass.

Hodgson, S. Ormond, A. W.

PRELIMINARY SCIENTIFIC (M.B.) EXAMINATION.

ENTIRE EXAMINATION.

First Division.

Butler, J. A. Hare, G. W.
Camps, P. W. L. Penny, C. B.
Wrench, G. T.

Second Division.

Greenfield, D. G. Parrott, H. McD.

Chemistry and Experimental Physics.

Barron, R. M. Lacey, H. K.
Beattie, F. A. Pearson, A.
Dainow, S. Rees, M. J.
Forsyth, D. Tattersall, H.
Graves, D. S. Wetherell, F. C.
Wilson, F. E.

Biology.

Wood, M. D.

Final Conjoint Examination, July, 1895.

Medicine, Surgery and Midwifery.

*Beddard, A. P. *Rowland, W. J.
*Harnett, C. J. *Steward, F. J.

Medicine and Surgery.

Clark, R. F.

Medicine and Midwifery.

Alexander, H. Roberts, R. L.
Ashwin, R. H. Stuart, W. L.
*Beven, O. Vellacott, P. N.
Izard, H. E. Watson, C. E. S.

Surgery and Midwifery.

Daly, N. *Maxwell, E. J.
Hitchfield, A. R. Tipper, E. H.

Medicine only.

*Beadnell, C. M. *Jones, M. P.
*Byford, W. F. Lincoln, C. H. S.
*Coleman, J. J. Parfitt, J. B.
Culmer, J. W. *Stoner, H. B.
Dykes, P. A. *Wallis, S. S.
*Wise, H. M.

Surgery only.

*Coleman, E. Huckle, A. H. H.
*Duffield, E. A. Mathison, A. J.
Fothergill, E. R. Moorshead, C. W.
Garner, W. L. *Philipps, A. E.
Greene, A. J. Price, W. M.
Ham, B. B. Reed, J. C. G.
Hora, J. Winter, W. C. P.

Midwifery only.

Bird, J. W. *Shorland, E. T.
Butler, A. G. Thomas, D. W.
Rowland, F. W. Tyson, W.

*Denotes completion of examination.

Second Conjoint Examination.

Anatomy only.

Mason, S. H. Poole, C. C.

Physiology only.

Ashby, E. Payne, J. L.
Lewis, L. H. Penrose, A. W.
Salmon, C. A. C.

First Conjoint Examination.

Materia Medica.

Holman, T. E. Mitchell, W. G.
Pomeroy, E. H.

Second Conjoint Examination.

(Under Regulations Dated 1st January, 1892.)

Anatomy and Physiology.

Alexander, K. B. Nourse, A. W.
Baker, W. L. Outred, C. D.
Barker, H. J. M. D. S. Parrett, E. E.
Crawford, V. J. Powell, J. E.
Grellet, W. P. Roberts, J. H.
Kirkman, A. H. B. Saward, A. H. M.
Landon, T. H. W. Shepherd, C.
Marriott, O. Thomas, A. R.
Thomson, C. B.

First Conjoint Examination.

Chemistry and Physics.

Beale-Browne, T. R.	Evans, S. J.
Bignold, H. H.	Felton, E. H.
Brangwin, C. H.	Hicks, C. E.
Braund, H.	Higgens, H. A.
Brockwell, J. B. C.	Morris, H. E.
Browne, T. W. S.	Rodil, B.
Davies, A. G. Capel	Scott, E. F.
Denny, H. R. H.	Shorland, G.
Dismorr, H. B.	Talbot, A. W.
Edwards, C.	Westlake, B. B.

Practical Pharmacy.

Braund, H.	McLachlan, A. R.
Hope, W. B.	Rodil, J. J.

Elementary Biology.

Braund, H.	Jones, F. J. Felix.
Brockwell, J. B. C.	Mandy, P. S.
Denny, H. R. H.	Rodil, B.
Hall, R. W. B.	Segreda, F. A.
Higgens, H. A.	Stevens, W. A. G.

Elementary Anatomy.

Brangwin, C. H.	Jones, F. J. Felix
Edwards, C.	Palmer, W. Grimes.
Shorland, G.	

Reviews.

Microbes and Disease Demons. The truth about the Antitoxin Treatment of Diphtheria. By Edward Berdoe, L.R.C.P. Ed., M.R.C.S. Eng. (London: Swan Sonnenschein & Co.) Price 1s.

Mr. Berdoe may be an authority upon Browning, but his knowledge of Bacteriology can hardly be said to be sufficient to entitle him to write upon the subject of the antitoxin treatment of diphtheria. As an example of the "scientific accuracy" of the book, we may quote a sentence or two:—"We find in the blood of animals suffering from a particular disease, certain bacteria or microbes, but we must not jump to the conclusion that these bacteria are the cause of the disease; they may in some cases be only its effects. We find in most cases of true diphtheria a bacillus—Löffler's bacillus (it is named after its discoverer)—but you can have diphtheria without a trace of the bacillus, and you can have the bacillus without the diphtheria." In the first place, diphtheria bacilli are not found in the blood; secondly, to talk about bacilli being an effect of the disease is manifestly absurd; thirdly, Löffler was not the discoverer of the diphtheria bacillus; and fourthly, the last statement as to the occurrence of diphtheria without the bacillus is against the weight of evidence. This may be taken as a fair example of the inaccuracy of statement, the incorrectness of deduction and the unfair bias which characterises the book throughout.

Early Scoliosis, or Curable Curvatures of the Spine. By Percy G. Lewis, M.D., Honorary Medical Officer to the Victoria Hospital, Folkestone. (London: John Bale & Sons.) Price 2s. 6d.

A readable little book, giving shortly and concisely the description of the various kinds of exercises, etc., for the treatment of early scoliosis. Many useful hints are given with regard to the examination and diagnosis of early cases, and these are well worth remembering. The book does not profess to be a complete treatise upon the subject, but so far as it goes it will repay perusal.

The Climates of the Geological Past, and their Relation to the Evolution of the Sun. By Eug. Dubois. (London: Swan Sonnenschein & Co.) Price 3s. 6d.

A somewhat technical but highly interesting essay. The author first describes what he considers to have been the climate in past ages in different parts of the world, and then goes on to trace a definite connection between the condition of the climate and the evolution of the sun, and the amount and kind of heat given off by solar radiation. Finally, various interesting points are brought out with regard to colour vision; thus, for instance, the frequency of the occurrence of red-blindness is explained as an example of atavism, that is to say, it is a negative inheritance from that far away time, when the eyes of our ancestors were not yet sensitive to red rays, these being almost entirely wanting in the white stage of the sun.

Text-Book of Forensic Medicine and Toxicology. By Arthur P. Luff, M.B., B.Sc., Physician in charge of Out-Patients, and Lecturer on Medical Jurisprudence and Toxicology in, St. Mary's Hospital. (London: Longmans, Green & Co., 2 vols.) Price 24s.

As a text-book for students of medicine, we think this book is a little disappointing. The price is decidedly high, especially when we consider the large number of books which students have to buy, and that although the subject is doubtless one of great importance, yet its complete study is frequently deferred until after the qualifying examinations have been passed. The author has taken great pains to bring the book well up to date, and has enriched it by a series of plates of the more important poisonous plants. The treatment of cases of poisoning is dealt with at some length, and with considerable care; the description of symptoms, however, is not always very clear. The second volume, which is devoted to Forensic Medicine as apart from Toxicology, forms an excellent manual of the subject, being clearly written and not too diffuse, and yet having a sufficient number of illustrative cases to impress the essential points of the subject upon the reader's mind; it forms a most valuable book of reference. The book before us is well worth going to for guidance and help in any medico-legal cases in which we may become involved. From the student's point of view we would especially direct attention to the second volume, in that it will well repay perusal.

Sport.

Cricket.

GUY'S 2ND XI. v. LONDON HOSPITAL A.

This match was played at Edmonton, on the 17th of July, on the liveliest pitch imaginable. The scoring on both sides was remarkably fast, over 400 runs being made in four hours. Guy's fielding was, as usual, conspicuously bad, but the state of the ground was no doubt, to some small extent, the cause. The match resulted in a draw as follows:—

LONDON HOSPITAL.

A. B. Fry, b Palmer	81
E. C. Salt, b Palmer	4
D. Le Creu, b Palmer	51
A. Vallack, c Cleveland, b Palmer	5
D. Jackson, c & b Palmer	7
A. E. Gibbs, c Yorath, b Collins	17
J. Arthur, b Palmer	0
S. Butler, c Crew, b Collins	15
R. J. Rice, c Cawston, b Collins	1
C. Simson, b Collins	6
G. Over, not out	12
Extras	33
Total	232

GUY'S.

T. H. B. Yorath, c Jackson, b Vallack	12
A. J. Cleveland, st Jackson, b Vallack	39
J. Biggs, lbw, b Fry	0
W. G. Palmer, c Jackson, b Butler	25
E. J. Crew, b Fry	0
V. Collins, c & b Fry	0
A. E. Cawston, not out	56
W. M. Thomas, not out	46
Extras	7
Total	185

Anderson, Bignold and Cawston to bat.

Guy's Hospital Cricket Club.

REPORT OF SEASON 1895.

THE season 1895 finished up on July 13th at Honor Oak Park with a victory over Brentwood. Of the matches played this season, we have won 9, including two Cup Ties, lost 10, including the Semi-Final Cup Tie, and drawn one. Most of our defeats were sustained in the early part of the season, and were entirely due to the inexperience and lack of confidence of the team in general, which consisted as a rule of no less than nine new members; however, towards the latter part of the season we made great progress, our best performances being against Eastbourne, Brentwood—a strong team of the past—and Chelmsford.

With regard to the Cup, we survived till the semi-finals to be crushingly defeated by University, who, in the Final Tie, fell a victim to St. Thomas's. This is the first time since 1883 that we have been defeated in the Cricket Cup Ties, for although St. Thomas's held it in 1889 it was only because we were disqualified. We must, therefore, work up hard next season and try to regain our laurels.

RESULTS OF 1ST XI.

May						
4	v. Beckenham ...	lost	Guy's	117	Beckenham ..	340
11	v. Surbiton ...	lost	„	43	Surbiton ...	119
15	v. Hornsey ...	lost	„	120	Hornsey ...	312
18	v. Crystal Palace	won	„	148	Crystal Palace	100
22	v. Dunstable ...	lost	„	106	Dunstable ...	168
25	v. Mitcham ...	lost	„	126	Mitcham ...	167
June						
1	v. Hornsey ...	lost	„	174	Hornsey ...	214
8	v. Bickley Park ..	lost	„	54	Bickley Park .	113
12	v. Brentwood ...	won	„	240	Brentwood ...	42
15	v. Eastbourne ...	won	„	257	Eastbourne ...	124
18	v. Croydon ...	won	„	209	Croydon ...	171
22	v. Mitcham ...	lost	„	92	Mitcham ...	179
24	v. Surrey Club and Ground	lost	„	133	Surrey Club ..	265
26	v. Past ...	drawn	„	296*	Past 7 wickets	190
29	v. Chelmsford ...	won	„	218	Chelmsford ...	171
July						
6	v. Streatham ...	won	„	123	Streatham ...	116
13	v. Brentwood ...	won	„	190	Brentwood ...	144

* Signifies innings declared closed in the Past Match, Guy's declared for 7 wickets.

CUP TIES.

June 10th.—v. Westminster Hospital. Guy's won by 6 wickets. *Scores.*—Westminster Hospital, 66; Guy's Hospital, 210.

July 1st.—v. King's College Hospital. Guy's won by 6 wickets. *Scores.*—King's College Hospital, 77 and 79; Guy's Hospital, 120 and 37 for 4 wickets.

July 8th.—v. University College Hospital. University won by 7 wickets. *Scores.*—Guy's Hospital, 78; University, 348.

BATTING AVERAGES 1ST XI.

	No. of Inns.	Times not out.	No. of runs.	Most in Inns.	Average
C. A. Trouncer ...	2	1	127	105*	127
A. E. Clarke	20	2	539	79*	29·9
K. B. Alexander ...	22	—	467	87	21·23
A. Perks	25	2	470	61	20·43
E. D. Hancock ...	11	1	202	76	20·2
F. C. Wetherell ...	5	1	58	44*	14·5
R. T. Fitz-Hugh...	6	2	55	30*	13·7
L. Humphry ...	21	2	238	48	12·5
F. J. Nicholls ...	8	1	62	25	8·9
P. D. Hunter	21	4	144	35*	8·45
N. Lavers	23	3	168	41	8.4
E. J. Crew	11	1	81	21	8·1
E. G. Goddard ...	22	3	135	26	6·1
F. Featherstone ...	12	3	50	9	5·5

*Signifies a not out innings.

BOWLING AVERAGES OF 1ST XI.

	Runs.	Wickets.	Overs.	Maidens.	Average.
C. A. Trouncer ...	125	13	39·2	12	9·6
F. C. Wetherell ...	133	11	53·2	10	12·09
A. E. Clarke ...	864	68	333·4	86	12·7
N. Lavers ...	257	16	92·3	20	16
E. G. Goddard ...	616	37	236·3	60	16·65
B. B. Ham ...	66	3	20	3	22
P. D. Hunter ...	267	12	87·2	10	22.25
F. J. Nicholls ...	221	9	41	2	24·6
A. Perks ...	134	5	40·1	8	26·8
E. D. Hancock ...	40	1	16	4	40

Trouncer bowled 2 no balls; Clarke bowled 1 wide Lavers bowled 1 no ball; Goddard bowled 3 no balls Hunter bowled 9 wides and 1 no ball; Perks bowled 1 wide.

A. E. Clarke.—Two bowling performances worthy of note, v. Bickley Park, he took 9 wickets for 43, and v. Brentwood, at Brentwood, 8 for 16 runs.

GUY'S 2ND XI.—SEASON 1895.

This has been a most disastrous season in every way, and all that can be said about it is lamentation and woe. The trial match played at the beginning of May failed to introduce the number of new men hoped for. Half a dozen of the men we counted on were kidnapped by the 1st XI., and we were left with one bowler and no reliable bat. It is much to be regretted that, in spite of our having so many cricketers at Guy's who could have added very considerably to the strength of the XI. had they liked, there should have been so much difficulty in raising decent teams. If players would realise how uncommonly disagreeable it is to ask men to play on the morning of the match who have not got their things, and who would have liked to play had they been asked earlier, there would be fewer cases of scratching at the last minute. In EVERY 2nd XI. match this season the team has been incomplete until the last morning, and that by two, three and, on two occasions, five places. Palmer, as our "one bowler," has been our mainstay, besides contributing two or three very fine innings. To sum up, of the 12 outside matches played we have lost 7, won 3 and drawn 2. The following are the averages of those who have played most frequently for the 2nd XI.:—

	No. of innings.	Not outs.	Runs.	Average.
G. R. Levick	8	2	121	20
W. G. Palmer.....	9	0	176	19
A. E. Cawston ...	10	2	139	17
J. De Coteau	7	1	97	16
W. Thomas.....	10	3	96	14
E. I. Spriggs	7	1	85	14
T. Morgan	8	0	84	10·5
C. T. Anderson ...	13	0	116	9
H. Darbridge	6	0	44	7·4
T. M. Walker	5	0	28	5·6
H. Bignold...	7	1	19	3
G. Shorland	7	0	11	1·5

United Hospitals Water Polo Cup.

GUY'S v. ST. BARTHOLOMEW'S.

FINAL TIE.

The final tie for the above cup was played at St. George's Baths on Thursday, July 25th, and resulted in a brilliant win for Guy's by five goals to nil. The cup has been in existence since 1892, and was won by Bart.'s in 1892-93, while last year it changed hands and passed over the water to Thomas's. The holders were defeated in the first round after a well-fought game by 2—1, but in the final our team had much the best of the argument and were never in difficulties, being in fact greatly superior to their opponents at all points of the game. Some brilliant shooting was seen on the part of Wood and Styer, and it may be said that the whole team played up to form and carried no passengers. Our goals were shot by Wood (2), Styer (2), Marshall (1). Teams:—

GUY'S.—G. W. Simpson (goal); J. L. Payne, A. R. McLachlan (backs); A. St. John Styer (half-back); W. R. Wood, S. Marshall, centre, V. E. Collins, captain, (forwards).

ST. BARTHOLOMEW'S.—F. K. Weaver (goal); W. Fay Bennett, captain, W. F. Godrington (backs); J. S. Mackintosh (half-back); G. B. Nicholson, L. A. Walker. (centre), T. Littles Jones (forwards).

Guy's Hospital Lawn Tennis Club.

GUY'S v. COVENTRY PARK.

This match was played at Coventry Park on June 29th, and resulted in a win for the home club by six matches to three. Clarke and Pendred played well for the Hospital, and had it not been for them, we should have made a very sorry show.

GUY'S HOSPITAL STUDENTS v. THE STAFF.

This match, which is to be hoped will result in an annual event, took place on July 23rd, the Staff receiving 15 points, and resulted in a win for the Students by 4—0, after a very enjoyable game.

Birth.

HOLMAN.—On July 30th, at Hoathly Lodge, Eastbourne, the wife of Henry J. Holman of a son.

Marriage.

PANTIN—HUTTON.—On July 10th, at the Parish Church, Pocklington, Charles S. Pantin, M.D., F.R.C.S., to Anna, daughter of the late Rev. Francis P. B. N. Hutton, Vicar of St. Saviour's, Leicester.

Death.

LORD, PERCY, M.B. Lond., M.R.C.S. Eng., L.R.C.P. Lond., R.N., died on June 8th, at Formosa, from Malarial Fever followed by Pneumonia.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

AUGUST 24, 1895.

Clinical Lectures on Cancer of the Tongue.

By the late ARTHUR E. DURHAM, F.R.C.S.

(Given on February 25th and March 2nd, 1874.)

[Note.—Shorthand reporter's transcripts of one or two Clinical Lectures being extant, it is thought that they may be not without interest to the readers of the Guy's Hospital Gazette. The following lecture on Cancer of the Tongue was given at a period when the galvanic snare was in vogue. Subsequently Mr. Durham always employed scissors for the removal of the tongue: besides the more ordinary forms he was fond of using his "cut-round-the-corner" scissors for the purpose.]

Mr. Durham, in proceeding to deliver this lecture said—Gentlemen, the special subject to which I wish to direct your attention this morning is Cancer of the Tongue. It so happens that I have three cases in which I have removed larger or smaller portions of the tongue affected by this disease. Cancer is not only a serious disease, but it is also rather difficult to deal with. It occurs, as a rule, in an advanced period of life; but you will nevertheless meet with cases at an earlier stage of life also—occasionally. The first case to which I wish to draw your attention, is that of a man who has recently been in the ward, but who is now cured, and quite able to leave. In fact, he is only waiting here to-day in order that I may bring him before you, so that you may see the results which have been attained. His age is 55, and by trade he is a gold and silver refiner. The history he gives is this. His general health has been good, and he has not suffered from any previous disease, or accident; and although a gold and silver refiner, he has never been rendered seriously ill from the fumes arising in carrying on his occupation. He has had an attack of gonorrhœa when young, but otherwise no venereal disease whatever. He has been subject to sore throat, which he thinks may have been due to the acid fumes. I refer to this especially, because you are all aware that sores on the tongue, and affections of the tongue are very common indeed in association with syphilis. They may come as a primary, or as a secondary, or also as a tertiary affection of the tongue. Gumma will also form in the tongue, and this you will see after I have illustrated the case to you. I should say to you, by-the-bye, that the most important point in diagnosis is to distinguish *cancer of the tongue* from some *syphilitic affection.* In this case we have no syphilis. There is no doubt about the cancer of the tongue at all. No one who has seen it can for a moment question that. There is no mistaking such a case of cancer; but still the early history of the patient should be taken into account. Three months previous to his admission the patient had a cold, and sore throat, and his tongue became rather swollen on the right side. His second bicuspid tooth, and the three adjacent molar teeth on the right side of the inferior maxillary irritated the tongue and caused it to ulcerate. The just-mentioned teeth were extracted, and the patient has since been under medical treatment, but found it of very little value, and that it did him very little good. On admission, the tongue exhibited an ulcerated cavity on the right side. The greater part of the middle of the tongue, from the median line to the right margin, was raised into a rounded prominence, with one or two smaller elevations, opaque and yellowish in colour, not unlike some fibrous mass about to slough out. The edge of the organ was warty-looking and on the right side thick and excavated.

There was in the tongue-substance a mass of new growth, which we find in cases of this kind. It was very thick and very hard, and besides that, the patient suffered a great deal of pain. There was no enlargement of the glands of the submaxillary region. His speech was thick, and he could scarcely make himself understood. There was an anxious expression about him; but otherwise he was a healthy man. In these cases of cancer of the tongue, it will be well to consider what steps have been taken recently in the mode of treatment. What is the treatment? We need not discuss whether it can be got rid of or not. If it is possible to remove it in any kind of way it must be done. Now, the first method is the application of caustic. I have never seen any good come from that application to the tongue. It only serves to irritate, instead of destroying.

If you have an enemy, do not tease him. It is no use stepping on a snake until he bites you. You must kill him. You must strike him off. Do not irritate a cancer. If you do, you will make a mistake. The glands will begin to get infiltrated. Do not, therefore, irritate the enemy, but stamp him out, so that you may have nothing more to do with him. We will not discuss a matter so trifling, then, as the application of caustic. That the application of liquid caustic does harm there is no doubt whatever, and I have seen that over and over again. Now, the question is, what is the best method to be adopted. That must depend upon the situation, and also the extent, and size of the cancer. We have to deal with a cancer of the tongue, and we dismiss the application of caustic. It is out of place. As I have said, then, what are the methods to be adopted? First of all, there is the old-established method of using the knife, and cutting the thing out. I need scarcely tell you that my feeling is that there is no instrument half so efficacious, and which gives rise to so little pain, as the skilful use of the knife. There is no instrument to be compared to it, even in certainty in doing what we propose to do, or as regards all risk and after pain to the patient. There are drawbacks, however, even in the use of the knife. I need not tell you that in operating on the tongue there is a great liability to bleeding; and not only that, but the parts bleeding are in a situation that is difficult to control. And not only is it difficult to control, but the bleeding may lead to great danger by the blood getting into the larnyx. So, therefore, it is desirable to avoid in the mouth any occurrence of hæmorrhage, and to avoid using any instrument in any way as to cause it. First, because of the arteries; secondly, on account of controlling the hæmorrhage; and thirdly, for the reason that hæmorrhage is liable to give rise to certain special danger, through the blood getting into the larynx and air passages. So, although in certain cases the knife has been used, there is a risk as regards the air passages when the vessels are divided, and when they cannot be conveniently compressed, and where you cannot make what, in some cases, is called a bloodless operation. Then, again, you must observe this: supposing you operate upon the tongue with the knife, you want the patient's assistance in getting rid of the blood, and in order to have his assistance he must not be under the influence of chloroform. That makes a great difference as regards the operation. If you have a patient under the influence of chloroform, you can go on comfortably. You have not the unhappy knowledge that the patient is suffering under your hands, and you can go about your work effectually, and complete your object. But in operating on the tongue with the knife, as I have already said, hæmorrhage is likely to occur, and for that reason we require the patient's assistance. The tongue is extremely sensitive, and an operation on that organ is very painful. Cutting gives rise to a great deal of pain. But if the operation is carried out with chloroform it may be seriously dangerous.

Another method of getting rid of cancer of the tongue is by means of a ligature. I have done so in a considerable number of cases of cancer of the tongue. In such case, the growth being strangled, dies, and gradually sloughs away. In this case there is no risk of hæmorrhage; but just think what must take place and how painful such an operation must be. We all know how nervous and sensitive the tongue is; the pain is very severe. Again, the process of cure is dangerous. After the patient has submitted to the pain of the ligature the process is still going on. Sometimes it takes many days, and all the time there is this stinking mass in the patient's mouth. You may conceive what a horrible situation the patient finds himself in. Still, patients seem to have less dread of this than the knife. But still, as I have said, there are objections to this method.

There is another method of removing portions of the tongue, and that is by means of the écraseur. A chain or wire is passed round upon the portion to be removed, and then by working the screw-handle the chain or wire is made to cut its way through the part to be removed. This instrument has been used here frequently. It is a French invention, and in a great many cases has been proved efficient, in so far as the object is to complete the operation at once, and without risk of hæmorrhage. By the use of the écraseur, the vessels are torn through gradually. Torsion is being practised upon the vessels while the cutting through is being accomplished. But still this method is a slow one. I have removed several portions of the tongue by means of the écraseur.

We have, however, now a far better method of operating, and that is the method I have adopted in the cases to which I wish to call your special attention; and that is the method which I recommend until I can find a better one. It is by the use of the galvanic cautery. Now, I will return to our patient. On the 19th of December the patient was brought into the theatre and placed under the influence of chloroform. I found that in his case I should probably have to remove three-fourths of the tongue in order to extirpate the whole of the part diseased. How are we to get the wire of the galvanic cautery round the affected part of the tongue in order to make it do its work effectually. Some might say you can slit open the cheek, and so get more room to pass the wire round the tongue. I believe we are indebted to Mr. Nunnerly, of Leeds, for the following method of putting the wire round the tongue. He said, by making a slight incision below the lower jaw, the wire could be passed up to the floor of the mouth, and carried well round the tongue. The suggestion was an admirable one. Previous to that, however, Mr. Symes adopted a different method. His method was by cutting through the lower jaw, and by separating the parts the whole tongue was got entirely under control. But such a position is a very serious matter. The preliminary steps place the patient in a very serious position.

Some years ago I performed this operation on a child, but I do not think I shall ever do so again. The little

child was 2½ years old, and by the process I have mentioned I was enabled to remove the whole portion of the tongue affected with growth. Mr. Nunnerley's plan was that, instead of thus separating the jaw, a little hole should be made in the inner aspect of the jaw, so that the wire of the galvanic snare could be passed into the mouth and over such portion of the tongue which it was found necessary to remove. In several cases I have simply adopted the method as recommended by Mr. Nunnerley. But he and those who have followed him say that the hole should be made in the median line to avoid hæmorrhage and damage to the glands which lie on either side. You will recollect that there are—passing from the internal surface of the lower jaw to the hyoid bone—two very important muscles, the genio-hyoidei and the genio-hyoglossi. These serve to pull forward the hyoid bone, which also brings the tongue forward. If these muscles are divided, then the tongue has a tendency to fall backwards. If you have a knowledge of anatomy you will see at once what the result would be. The epiglottis may fall back, and thus lead to suffocation. As long as the hyoid bone is kept forward the tongue must also be kept forward to a certain extent. But suppose the genio-hyoidei muscles are divided and the epiglottis falls backwards, the tongue drops over the larynx and leads to suffocation.

In the first case in which I performed an operation where I used the galvanic snare I very carefully passed the knife in the median line, on the inner side of the lower jaw, and cut off satisfactorily all the portions of the tongue I wished to remove. But immediately that was done, the other portion of the tongue went back, and the patient was in great peril. It was the work of a moment to pass the cord round and hold it till the patient recovered. That is the kind of accident I have been trying to explain to you. If you pass the wire in the middle line you will detach the genio-hyoidei muscles, and thus risk the tongue falling back and carrying with it the epiglottis, and that dropping backwards prevents air passing into the lungs, and so gives rise to suffocation. You may say this is a little point, but still it is a point. This case which I operated upon, instead of passing the knife up in the middle line, I passed it along the right side of the middle line. What then did I penetrate? The skin. Then my object was to go between the submaxillary gland and the lower jaw to the mucous membrane. I then thrust the knife through and a little blood came, probably from the facial artery. By means, then, of a guide, I passed the wire of the galvanic cautery up into the mouth, and here you see I was right on one side of the middle line, and the tongue being seized by forceps was pulled through the loop or wire and put into such a position as to encircle the tongue, and cut behind any part of it in which there exists any cancerous deposit. The tongue, being, as I have explained, secured in the loop of wire, and the wire being heated, it gradually burned its way through that portion of the tongue required to be removed. When the tongue was cut through the anterior part came off, but not a sign of bleeding occurred. Not a drop of blood was lost. What did happen was this: After the portion of the tongue was cut off and the genio-hyoidei muscles came into play they pulled forward the bit of the tongue which was left. After the operation the patient went on well. There was not a single bad symptom whatever. He is here now and I will call him so that you may see him. Here is the portion of the tongue removed. I will pass it round and you will see how large a portion it is. Here is the cancer and here is the tongue. The other portion of tongue is from a female patient. [By direction of Mr. Durham the male patient opened his mouth, which was inspected by the students]. You see the portion of tongue which is left. Examine it carefully. You see how perfectly the tongue is healed over. The wound below is perfectly healed. He will show you how well he can speak. And the subject to which I wish particularly to direct your attention to to-day is the manner in which the clearness of speech is preserved or regained after the operation.

At the request of Mr. Durham the patient spoke.

Mr. Durham continued: You hear how well he speaks. I promise him and you that if he continues to go on as well as he has that he will speak in six months' time so much better that you will not know that he has lost anything like such a considerable portion of tongue. He is a very good illustration to show how much of the tongue can be removed without any serious detriment. You see how much he has improved.

The patient here asked if he might smoke tobacco, to which Mr. Durham replied in the affirmative, but that he should advise him to use a pipe with an amber mouth-piece.

The next patient, a female, was then introduced, and, after being examined, withdrew from the theatre.

Mr. Durham then said: You see this poor woman; I removed a cancer from her tongue a year ago last August. It has healed up entirely. It was a much smaller one than the one taken from the first patient. The interesting point in this case was that she had an enlarged gland under the lower jaw. This has increased in size, and the structures became injured, and the hyoidei muscles infiltrated. The muscles of the lower jaw were infiltrated, and there was an enormous swelling of the maxillary region. It was just one of those cases in which years ago persons would have said nothing could be attempted; but I thought of her sufferings, and looking upon her as a healthy woman, who would live some years longer in health and comfort, I made up my mind to try and do what I could to relieve her. The cancer you see is removed; the wound is entirely healed up, and the muscles and maxillary region and the whole of the lower jaw all right. She is getting on quite well, and is very much better for having it done. You see how well she has recovered from this formidable operation. I must not, however, detain you any longer, but I will just direct your attention to the microscopes, and on the next Wednesday I will finish up this case, and

then proceed with other cases to which I wish to direct your attention.

You will recollect, gentlemen, that when I left off my last lecture I had not entirely finished my observations with reference to the subject with which I had to deal, namely, cancer of the tongue. I will, then, just revert again to that subject, and afterwards pass on to speak of those other cases which are afflicted with diseases in different parts of the body. In my last lecture I discussed pretty fully the case of J—— N——, who occupied No. 8 bed in Naaman ward. He was suffering from cancer of the tongue. That old gentleman, you will remember, lost three-fourths of his tongue, which was removed by means of the galvanic snare cautery. I called your attention in the first place to the diagnosis of the disease from which he was suffering, and in the next place to the mode of treatment which I adopted in his case. I told you that this was a case of epithelioma or epithelial cancer of the tongue, which is distinguished from syphilis of the tongue.

I am now going to point out the difference between the two. Let me, then, first call your attention to the mode of distinction. I may say, however, just in passing, that a good deal may depend upon the age of the patient and the previous state of his general health. Syphilitic affections of the tongue take place at an early age, while epithelial cancer rarely occurs to a patient under forty years of age. In the next place, syphilitic affections of the tongue are more or less central in their situation, and commence in the form of ulcerations, and very frequently there are several of them. Epithelioma of the tongue commences at a single spot, as a general rule, and usually occur on one side or the other. They are not, therefore, central in their position. Next, as a general rule, in a large number of cases epithelial cancerous affections of the tongue appears to follow some kind of irritation—for instance, from the scratching from bad and jagged teeth. Again, it is caused by the irritation arising from a clay pipe. Understand, mind, smoking does not cause the irritation; it is from a sore occasioned by the clay pipe injuring the lip or the tongue. A distinguished surgeon once made a very great fuss in the *Lancet* about cancer of the lip, which he said was caused by smoking. Cancer in the lip or tongue is not occasioned by smoking, but by the irritation arising from the effects of using an unwaxed clay pipe. Everyone knows how such a pipe will adhere to the skin of the lip. It will naturally stick to the moist surface, and thus give rise to irritation which often ends in cancer. I propose, then, to draw the distinction between syphilitic affections and cancer. Syphilis occurs without any special local irritation, while epithelial cancer generally follows some special local irritation. Examine this tumour, and you will find that the epitheliomatous affections are slower, or else the ulcerations are more or less circular in their outline, or the number of circles are joined together, whereas, on the other hand, the outline of a syphilitic sore is more oval than circular. In the next place, the pain arising from a syphilitic sore affecting the tongue is, generally speaking, but trifling. But in epithelial cancer of the tongue the pain is very acute. In syphilitic affections of the tongue, the ulcerations are, generally speaking—note that I am using the word generally; there is not any hard and fast rule; there is not any rule which is invariable—generally speaking, then, syphilitic affections of the tongue are followed by ulcerations. That is the first thing, and ulcerations are in turn followed by indurations. But this does not present a hard or stony appearance which is the characteristic of epitheliomatous affections of the tongue. On the other hand, epithelial cancer of the tongue forms in a bigger lump than an ulcer. Ulceration takes place after; there is not any ulceration at first. Ulceration is of a secondary kind. Then again, observe that in epithelial cancerous affections there is a hardness from the very first. This hardness means infiltration of the structure of the tongue, and this infiltration means the impeding of the movements of the tongue, and, of course, also means an interference with the speech. Here you have the speech interfered with to an unmistakable degree, while in syphilitic affections of the tongue the speech is not at all interfered with or impaired. In epithelial affections of the tongue the glands sooner or later become enlarged, and sooner rather than later the glands may become enlarged, but such a state of things occurs later rather than sooner in syphilitic affections of the tongue; and the disease yields slowly to treatment. In epithelial cancer of the tongue the disease gets worse and worse, and the only treatment you can use, is to cut it out by cold steel or by the heated wire of the cautery. You will thus remove the whole of the diseased portion of the tongue. In syphilis nothing would be more foolish or more cruel to the patient than to resort to such an expedient. I have drawn your attention to syphilitic and general affections of the tongue, because there are so many cases occurring where it is difficult to diagnose the distinction between them. It is of the greatest importance that you should make your diagnosis correctly, and by-and-bye, when I come to speak to you of other forms of malignant disease occurring in other parts of the body, I shall again have to remark on the difficulty of diagnosis between syphilitic affections and malignant growth occurring in certain parts of the human frame. Speaking generally, if I were asked which is the greatest difficulty, and which is most likely to be confounded with them, I should say some form or other of syphilitic disease. One of the very first points is the general state of the constitution. Again, there is that which is spoken of as cachexia or "bad blood," and a general deterioration of the health, that is a general constitutional derangement. This we are told to regard as an indication of the existence of malignant disease in an advanced stage of syphilis, with its general deterioration of the constitution, and here you get the kind of constitutional distinction which is indicative of cancerous disease. I hope you will not think I have

been dwelling too much on this point; but I want you to understand distinctly that unless you are careful not to confound syphilitic affections with corresponding cancerous affections, and if you go on treating a case as if it were syphilis until the neighbouring structures get infiltrated nothing will stop the progress of the disease, and it will precipitate your patient unto death. If you cut out cancerous disease do it thoroughly and completely, as well as the neighbouring parts of the organ. If you do that the part from which the cancer has been removed will assume a healthy aspect, healing will take place at once, and the patient will go on well. But if you cut out a bit affected by syphilitic disease, the part from whence you have cut it will bear an unhealthy look. This is clearly a clinical way of talking. The case to which I have directed your attention was one of epithelial cancerous affection of the tongue. There was extensive ulceration, surrounded by under rooted growth. There was, in fact, a quantity of new material on the tongue, and there was very great pain associated with it. The tongue was impaired in its movement. All sorts of therapeutic treatment had been tried in vain. In spite of all the growth went on increasing in size. The ulcerations went on spreading. Now we come to the treatment. There was no hesitation about the treatment at all, and that was the entire removal of the whole of the portion of the tongue affected by the disease. It was accomplished in the manner which I described to you in my last lecture, namely, by the galvanic cautery snare. I showed you the portions of the tongue on the last occasion, and which consisted of the structure of the new growth. The patient, you know, got on well. You will recollect, too, the great point as regarded the method adopted in the removal of the growth from the tongue. It was done without cutting through the cheek or making any large opening whatever. You pass the loop through, below the lower jaw, on one side of the median line. The correctness of this method is shown by the result. No damage was done to the genio-hyoid muscles. If the genio-hyoid muscles had been damaged the stump of the tongue would have fallen back, and might have led to suffocation. That was the subject discussed on the last occasion, and evidenced the success of the little modification in the operation which I ventured to adopt. I say that success was clearly shown in this particular case. It was further illustrated in a case which I shall presently draw your attention to.

The operation on the old gentleman occupied but a very short time. You saw how the stump of the tongue had healed over, and those of you who put their fingers in his mouth could not feel any portion of cancerous growth remaining, nor could you detect any glandular enlargement below the lower jaw. I am sure, when some of you are settled in practice in the country and come up to town, you will think of this and give a look in at Guy's to see how we are getting on. You will, I have no doubt, reflect upon this operation, and be gratified at the relief given to the patient.

We have another patient in the Hospital, and to this case I wish now to direct your attention. W. B., 60 years of age, No. 6 in Naaman ward. His general health was fairly good up to the last five months. In this case the growth was quick. One of the left molar teeth gave him some trouble. You will now see how cancer arises from local irritation. Every sore on the tongue, however, is not attributable to the teeth. This arose from local irritation, just as epithelioma of the lip almost invariably starts with and follows upon some local irritation. Bear in mind, gentlemen, we are talking over the matter clinically. Cancer is in reality at the commencement a disease engendered by local irritation.

Some years ago Dr. Abernethy gained great credit for calling the attention of the profession to local disease; nowadays we have some local origin for constitutional diseases. I believe that in a large proportion of cases cancer begins as a purely local affection. There is a capacity for growing, just as a dunghill has for growing mushrooms. Syphilis is a constitutional affection, but still it has a local origin; and some constitutions are particularly prone to catch it. This patient had, as I have said, a bad molar tooth, which scratched the side of the tongue, and a small ulcer was formed in consequence. The tooth was extracted, but the ulcer did not heal; it got worse and worse. There was something more than irritation from the tooth, otherwise the ulcer would have healed up. He went ultimately to an institution for diseases of the throat, and where he paid a guinea a week. Caustic was applied to his tongue; and after having spent all his money without any good being effected, he came out of the institution. I wish to emphasize this point. It is no use trifling with this disease. Don't do it. If you irritate a cancer you will make it worse; and you will raise up a kind of spirit of opposition to your efforts. The glands will become much more speedily affected. We do not expect to have glandular affections from a sore; but if you irritate that sore, as I have said, glandular affections will follow. For instance, where there has been a blister on the heel, if you put something soft over it, you at once save it from being irritated, and the sore heals; but if you go walking about with shoes which irritate the sores, you will find in a few days glandular affection and an enlargement in the groin. You will find an unhealthy appearance presented round about the sore. Irritating these things, then, will make them unhealthy, and lead to the terrible affection of cancer. Just in the same kind of way, if you have any cancerous affection, or any venereal sore, if you apply to it that which will irritate, and not destroy, the effect will be that you will have glandular affections occur. If you destroy the sore absolutely, you may effect a cure; but if you simply irritate, and fail to destroy, you will most assuredly do a great deal more harm than good.

So far as I know, and I have seen a good deal with reference to the application of caustics, I may say that there are certain affections in which and for which the

proper application of caustics may prove very efficacious indeed, and may also be a most appropriate means of treatment. But I have yet to learn that caustics in cancerous affections of the tongue will destroy the cancer without subjecting the patient to an unjustifiable amount of pain and suffering. I say, as far as I know, that by the mere application of caustic to a cancerous growth of the tongue it is impossible to lead to a satisfactory and good result; and it not being possible to lead to a good result, it must, perforce, lead to a bad one. In this case, no good was done; the man got worse. Then he came here in a very bad state indeed. I am not, however, going to trouble you with a detailed description of the cancerous affection. The nature of the disease no doubt you have fully recognised, and the character of the disease presented to you, I need hardly repeat, was as marked as it could be. I performed the operation by means of the galvanic cautery. The effect has fully realised the success of the method adopted, and since the operation the patient has gone on well, but not quite so well as the patient I spoke of in the first case. You see here, too, in this case there was a little portion of the cancerous growth which was rough, and cut through, and so it might seem that the whole of the part of the growth was not entirely removed; and if I had been able to detect any cancerous nodules existing I should have sent the wire further back. But when there is a hard mass on the surface, it is impossible sometimes to feel these little nodules. Well, then, I removed the cancerous growth from the tongue, and the patient is going on very fairly well, and continues to wash his mouth out with permanganate of potash. But it caused a slough, and I find that no portion of the cancerous nodule now remains; but if it does, I shall proceed to destroy any portion that is there.

Well, I have been speaking to you about the method of removing the greater part, or the whole of the tongue, affected; but you must not suppose that it is necessary in every case to remove so great a portion of the organ. The rule is to leave as much as you can. Do not in any case remove any portion of the body unnecessarily. Do not remove an atom for the removal of which there is not some sound reason. But while you take care to do that, take care also to remove all that is actually necessary. Do not leave behind any seeds which may develope and grow. Remove, then, what is necessary, but leave alone that which it is unnecessary to remove. The female patient whom you have seen was in Dorcas ward. She came under may care eighteen months ago. In that case the cancer on the tongue was small, and I had not to remove so large a portion of the tongue. The other two cases came under my treatment later. In her case, there was one small globular cancer on the surface. The tongue was dragged well forward, a portion of the tongue was transfixed behind the base of the growth by two needles, the wire was pulled round the base of the growth, and the wire being heated cut off the growth. They were ordinary steel needles. I mention this because you may think they would act contrary to what you would expect, and not be likely to be successful. Theoretically, it might be said that the current would be likely to be destroyed by using these steel needles: but, practically, I never saw it. One surgeon has used some ivory needles, like knitting needles, passed through the base of the growth. I have not found any difficulty in my process. Indeed, I think it is much easier than the other plan of having ivory needles. It is not, however, of much importance. It is a matter of fact that steel needles were used and I removed a portion of the woman's tongue. Her case presents a more distinctive feature than the other patients. They had no glandular enlargement, but the woman had an enlargement of the submaxillary glands. You may get a sympathetic glandular enlargement. It is not a very good word to use, but is used—let it pass, please. You may get this enlargement from any irritated surface. You may get this enlargement from infiltration of the glands from some material irritation of the ulcerated part, and you may get cancerous infiltration of the glands. I have seen cases of epithelioma in which glandular enlargement existed, but in which also it decreased in size, and almost disappeared after the epithelioma had been removed.

It was in August, 1872, when she was operated upon. The gland got very much smaller, however, and she went out of the Hospital, and stayed away for eighteen months or two years. When she came back the gland had increased in size. Iodine had been employed, and as is said, everything was done that could be done, but to no purpose. She looked as if she had a cancerous affection of the lower jaw. However, looking at the woman as generally healthy—that is, of course, a very great thing; she is a good sort of woman—and looking at her as likely to get over the operation and live for a considerable number of years, I determined to remove the cancerous affection. I then proceeded to operate, as some of you saw, on the 27th of June last. I made a bold incision. Now, mind this, never allow yourselves to become frightened. If you are frightened mischief will come of it. Take it easy and quietly, but firmly. Go boldly to work, but at the same time be cautious. Be bold, so that you may do well what you intend to do, but be also cautious, that you may not do what you do not intend to do. Somewhat to my surprise, and I need hardly say also to my satisfaction, by proceeding with caution in the operation I have mentioned, I managed to get away every part of the cancerous affection without cutting the jaw or making any opening into the mouth. [Mr. Durham here detailed the process.]

The poor woman has gone on well since, and there is not a single trace of any bad symptom. In point of fact, I may say that she has had most excellent symptoms all the way through. She takes her food well, masticates and swallows well likewise. She also looks well, and there is every prospect of her living for a considerable time longer than if the operation had not been performed.

Whether she has another cancer or not, this is certain, she will live in comparative comfort and freedom from suffering, both physically and mentally. You should always endeavour to save your patients from suffering, and above all, that worst of suffering—mental suffering—which leads them to think that they are going to linger out their lives in pain, and no hand will be held out to help them. Do not flinch in your object; never mind the statistical information given to you. It looks all very well in a book, but there is another book—the book of one's own conscience; the book of your own recollection that you have never lost an opportunity of affording relief to a patient because of your own risk of credit, and that you have tried to your utmost to preserve the life of your patients. Well, then, gentlemen, this case has done well, although I was, to a certain extent, criticised for attempting the operation; but anyone who did so then, will not do so now. I will now pass from the subject of cancer of the tongue.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	10.	Ulcerative endocarditis.
	21.	Anæmia.
	22, 25, 42.	Mitral stenosis and regurgitation.
	37.	Chlorosis.
Philip	3, 40.	Aortic and mitral endocarditis.
	8.	Mitral regurgitation. ? Pulmonary regurgitation.
	15.	Aortic stenosis and regurgitation. ? Mitral stenosis.
	28.	Mitral stenosis and regurgitation.
	33.	Mitral regurgitation.
	35.	Arterial atheroma. Two eclamptic attacks.
	40.	Mitral regurgitation. Bronchitis and emphysema.
Stephen	2.	Aortic and mitral endocarditis.
	6, 28.	Mitral regurgitation.
	31.	Mitral stenosis and regurgitation.

Nervous System.

Mary	1.	Disseminated sclerosis.
	16.	Cerebral tumour. Optic neuritis.
	40.	Apoplectic attacks. ? Cause.
	46.	Paraplegia. ? Cause.
Philip	17.	Paraplegia following influenza.
	30.	Idiopathic muscular atrophy.
	34.	Spastic paraplegia.
	37.	Locomotor ataxy.
	39.	Paresis of legs. Neurosis.
Stephen	13.	? Cerebral hæmorrhage.
	30.	Idiopathic muscular atrophy.

Alimentary System.

Mary	5, 33.	Gastric ulcer.
	14.	? Gastric ulcer.
	31.	Jaundice. Enlarged liver. Malignant disease.
	47.	Ascites. ? Cirrhosis.
	50.	Peritonitis. ? Appendicitis.
Philip	13.	Carcinoma of pancreas.
	18.	Dilated stomach.
	21.	Severe gastric attack. ? Obstruction.
Stephen	1.	Epithelioma of œsophagus.
	5.	Enterica.
	7, 24.	Leucocythæmia.
	36.	Dilated stomach from traumatism.

Genito-Urinary System.

Mary	6.	Tubercular cystitis and pyelo-nephritis.
Philip	1.	Chronic nephritis. Bronchitis and asthma.
	10.	Chronic nephritis. Cardiac murmurs.
	12.	Diabetes.
	14, 25.	Chronic nephritis.
	36.	Tubal nephritis.
Stephen	14.	Chronic nephritis.
	25.	Diabetes.
	34.	Acute Bright.

Respiratory System.

Mary	7, 23, 24, 27, 36, 43.	Phthisis.
	26.	Acute lobar pneumonia.
	35.	Pleuritic effusion.
	45.	Acute on chronic bronchitis.
Philip	2.	Phthisis. Pleuritic effusion, left.
	16.	Bronchitis and emphysema. Enlargement of liver and spleen. Ascites.
	19, 26.	Acute lobar pneumonia.
	31.	Phthisis.
Stephen	10.	Pneumonia. Empyema. Pleurisy. Pericarditis.
	11, 29.	Pleuritic effusion.
	19.	Phthisis.
	39.	Acute lobar pneumonia.

Miscellaneous.

Mary	8	Eczema.
	9.	Chronic gouty arthritis.
	19.	Acute rheumatism.
	28.	Recurrent erythema nodosum.
	30.	Pyrexia. Erythematous rash. ? Enterica.
	32.	Psoriasis.
Philip	7.	Purpuric rash on arms and legs.
	9.	Acute rheumatism. Purpuric rash.
	20.	Multiple sarcomata. Secondary growths in lung.
	29.	Mediastinal sarcoma.
	32.	Acute rheumatism.
Stephen	4.	Acute rheumatism.
	35.	Gonorrhœal rheumatism.
	11, 38.	Plumbism.

Case under Dr. Pye-Smith.

Mary 30. E. A. B., æt. 19, single. Admitted August 12th for pain in head, sickness, swollen eyes and lips. History of phthisis, and rheumatism in family. Her menses commenced when she was 15 and have occurred every two or three weeks; amount normal. She had not been well for two weeks, but on Friday, August 9th, she was taken worse with bad headache. On Sunday night she vomited. On Monday she was continually retching, and vomited about a dozen times. She came up to Guy's in the evening. She has taken no food since Sunday dinner.

Condition on admission.—Pulse 140; respiration 24; temperature 101°. Well-nourished girl. Face rather flushed; eyelids and lips swollen; tongue furred except at edges; bowels confined; skin is hot. There is a red macular rash over legs; also some on palms of hands, arms, chest, and abdomen. She lies quite still, but answers when spoken to. Mist. Salinæ ʒi. t.d.s., and milk diet were prescribed.

August 14th. Pulse 104, regular; respiration 24; temperature 103·2°. She had a bad night. Mist. Phenazoni ʒi. once or twice a day. Enema saponis mane.

15th. Lips are very sore; tongue very furred and dry: rash disappearing. Temperature 101·2°; respiration 24; pulse 108. She had a better night. She passed a semi-fluid motion after the enema.

16th. Temperature went up to 104·2° last night, but has fallen to 103·6° this morning.

17th. Ice to head. Enema Glycerini c.m.

21st. Patient had a very good night. The rash only remains on each side of abdomen. Tongue almost clean. Temperature has gradually fallen to 98·4°; pulse 100; respiration 20. Headache has nearly gone, and patient feels much better.

Dr. Pye-Smith considered the pyrexia and erythematous rash to label the case as enterica.

Case under Dr. Goodhart.

Mary 16. A. J. B., 28, married. Admitted August 8th for headache, vomiting, and weakness of sight.

Family history.—Unimportant.

Personal medical history.—Patient has had scarlet fever and rheumatism. She suffers from bronchitis in the winter. Also from frontal headaches, with sickness and temporary dimness of sight, ever since she can remember. ? Migraine. No history of fits or of any injury to head.

History of present illness.—About eighteen months ago patient felt her sight weak after reading, and says she felt as if she were going blind. Since Christmas she has had constant headache in left temporal and right occipital regions, with pain and impairment of vision in both eyes and frequent vomiting after food. Hæmatemesis three weeks before admission. Patient has been living on soda and milk for last month. Bowels constipated, and at times slight retention of urine. For the last six years patient has been getting very fat. Insomnia for some time past.

Condition on admission.—Temperature 98·8°; pulse 80; respiration 24. Patient is a very obese woman, and weighs 15 stone 7 lbs. No alteration in shape of head. No facial paralysis.

Mental condition.—Good.

Motor.—No wasting. Grasp of hands equal, and fairly strong. Patient walks fairly well, but only for a very short distance without feeling exhausted. There is a slight tendency to stagger and lean towards the right, but this is very slight.

Sensory.—No anæsthesia or hyperæsthesia.

Reflexes.—Knee-jerks absent.

Special senses.—Sight.—Impaired in right eye; quite gone in left; pupils slightly dilated. Reaction and accommodation normal. There is paralysis of left external rectus, and slight ditto of right internal rectus muscle. There is no nystagmus.

Ophthalmoscope.—There is well-marked retinitis in both eyes, with hæmorrhages and exudations in surrounding retina. Retinitis subsiding in left eye. (?)

Speech.—Normal.

Hearing.—Normal.

Respiratory and circulatory systems.—Normal.

Urine.—1016; normal; pale.

No evidence of syphilis.

The case was diagnosed as intra-cranial tumour. Position not localised.

Treatment.—Pot. Iod. gr. v.

Mist. Pot. Iod. ad. ʒj. t.d.s.

In the Surgical Wards.

Cases under Mr. Davies-Colley.

Cornelius	8.	Compound fracture of olecranon.
	20.	Compound fracture tibia and fibula.
Lydia	3.	Hydrops of knee. Enlarged semi-membranosus bursa.
	7.	Tubercular periostitis of ribs.
	13.	? Sarcoma of septum nasi.
	20.	Genu valgum. Recurrent synovitis of knee.
Luke	3.	Chronic plastic synovitis of knee-joint following an attack of gonorrhœa after an attack of acute rheumatism.
	5.	Suppuration in shoulder-joint following gonorrhœa.
	10.	Double reducible acquired inguinal hernia.
	18.	Deformity of knee, the result of injury.

Cases under Mr. Lucas.

Accident	12, 15, 16.	Compound fracture of tibia and fibula.
	25.	Fractured surgical neck of humerus. Fractured olecranon. Colles' fracture.
	26.	Fractured tibia at the junction of upper and middle thirds.
	26.	Concussion. Bleeding from ear.

Lydia	11.	Fractured patella.
	14, 16.	Carcinoma mammæ.
	21.	Mastoid abscess.
Job	2.	Pachyvaginalitis. Abscess in scrotal tunics. Removal of thickened wall of tunica vaginalis and redundant scrotal tissues.
	8.	Recurrent appendicitis.
	9.	Stricture. Peri-urethral abscess.
	16.	Acute *periostitis*.
	18.	Submaxillary tumour.
	21.	Mastoid abscess.
Charity	3.	Fractured patella.
	4.	Bronchocele.
	5.	Fractured jaw, humerus and ribs.
	Cot.	Hare-lip and cleft-palate.
	Cot.	Mastoid abscess.

Cases under Mr. Jacobson.

Martha	14.	Cyst of thyroid. Enucleation.
	15.	Ulcer of leg, with black, dry, horny discharge on it. ? Epitheliomatous.
Naaman	1.	Recurrent growth in glands of neck. ? Sarcoma. Excision.
	16.	Syphilitic (congenital) osteitis, legs and arms.
	17.	Enormously enlarged varicose veins (internal saphena). Phlebitis. Excision of *enlarged vein*.
	22.	Cleft-palate.
Dorcas	1.	Nævus of lip.
	3.	Spinal caries.
Charity	6.	Cyst of thyroid. Removal of right lobe.
	9.	Rapidly growing carcinoma in breast of woman four months pregnant.
	13.	Sarcoma of upper jaw excised four years ago. No recurrence and no deformity resulting.
	16.	Hydrocele of canal of Nuck on right side. Inguinal hernia on left.
	20.	Cyst in breast.

Cases under Mr. Dunn.

Martha	3.	Hydronephrosis. Movable kidney. Nephrorrhaphy.
	4.	Pes cavus.
	10.	Old fracture of femur. Two inches shortening. Flexion of knee.
	11.	Lupus of face. Hip-joint disease.
	17.	Malignant growth of rectum. Excision.
	18.	Lymphadenoma.
	Cot.	Nævus on abdominal wall. See method of excision.
	Cot.	Congenital talipes. Equino-varus.
Lazarus	1.	Fæcal fistula following enterotomy for intestinal obstruction.
	8.	Epithelioma of floor of mouth. Symes' operation.

The Arthur Durham Memorial.

It is proposed to raise a fund of £2,000 to endow in perpetuity two beds in memory of the late Mr. Arthur E. Durham. The following is the fifth list of subscriptions, and the Collecting Committee earnestly solicit the further help required to complete the fund.

	£	s.	d.
Corrected amount previously acknowledged	1,507	16	6
Wills, Frederick, Esq.	50	0	0
T. B. H.	10	0	0
Cox, Mrs.	10	0	0
Read, Lawrence, Esq., Hanover Square ...	3	3	0
Emmet, J. W., Esq., Croydon	1	1	0
Saffery, F. G., Esq., Camberwell	1	1	0
Booth, J. H., Esq., Chesterfield	1	1	0
Smith, F. H., Esq., M.D., Lewisham ...	1	1	0
Jones, W. A., Esq., Beckenham	1	1	0
Webber, H. W., Esq., M.D., Rickmansworth	1	1	0
Hickman, H. V., Esq., M.B., Wanstead ...	1	1	0
Badcock, J. H., Esq., Harley Street	1	1	0
Eyre, J. W. H., Esq., M.B., Guy's Hospital	1	1	0
Young, F. C., Esq., M.B., Alford	1	1	0
Batteson, J., Esq., Shepherd's Bush Road ...	1	1	0
Brock, E. H., Esq., M.D., Streatham ...	1	1	0
Dugon, F., Esq., Rotherhithe...	1	1	0
Brooks, Bransby, Esq., Sonning	0	10	0
Plummer, W. E., Guy's Hospital	0	2	6
Per Miss Hickson—			
Eschwege, Mrs. and the Misses, Forest Hill	3	3	0
"A Friend"	1	0	0
Per C. E. Carpmael, Esq.—			
Gordon, J. H., Esq., M.B., Cheadle	1	1	0
Milward, James, Esq.	1	1	0
Per N. Denham, Esq.—			
From Students of the Dental School ...	1	10	0
	£1,603	0	0

Case of Spastic Paraplegia Associated with a Pulmonary Systolic Bruit.

Mrs. C., sempstress, 41. Nothing of interest in family history except that her mother, æt. 73, had a slight epileptiform attack last year, followed by transient hemiplegia, since when her intellect has not been as clear as formerly; she is described as being "quite dull," sometimes for a week. Patient is of average height, spare, and of rather sallow complexion; is married, and has had only one child, a daughter, now 18, and healthy. Patient is very abstemious and regular in her habits; has been very healthy; does not remember any illness till she had severe "lumbago" thirteen years ago; has had two or three atttacks since then, not so severe as the first, which kept her in bed for some time. Has suffered at times from severe toothache and neuralgia.

I saw her once in the surgery in February, 1893, when she complained of amenorrhœa of three months' duration, and showed me a purpuric rash thickly distributed over both legs below the knees. I did not, unfortunately,

examine her further then, and lost sight of her till three months ago. The history then given was that for about two years there had been increasing fatigue on walking. The weakness was referred to the legs and back, and was not accompanied by breathlessness. For about twelve months sleep had been much disturbed by spasmodic flexing of the legs, increasing in frequency and violence till latterly she had often not slept at all. For about eighteen months the fingers had felt, in the morning, "as if asleep and as if a weight were hanging from each finger." A needle could not be picked up for some hours after rising, and the legs were so stiff and clumsy that there was considerable difficulty in coming down stairs in the morning. In a few hours all abnormal sensations used to pass off.

On examination (three months ago) the only abnormal sign found outside the nervous system was an extremely harsh, loud systolic bruit in the pulmonary area. Pupil and skin reflexes normal; sensation normal; intelligence and all special senses normal; no inco-ordination nor vertigo; stands well with closed eyes. A slight blow on the patellar tendon caused the leg to be jerked out almost straight; elbow tap exaggerated. Ankle clonus present in a moderate degree; patellar clonus much more marked and lasting longer; the legs were similar in these respects. No retinal changes.

Patient was put on iron and arsenic, and, very soon, on iron alone. In a fortnight the bruit had disappeared and she walked better. In about three weeks the abnormal sensations mentioned as occurring in the hands had ceased. Now, after three months' treatment, patient can walk as well as ever; heart-sounds are normal; there is no trouble with the hands; the spasmodic movements of the legs at night occur only occasionally and are comparatively trifling. Knee-jerks still very active, but not so much exaggerated as formerly; ankle clonus absent; rectus clonus present in a slight degree.

The disappearance of the bruit and the simultaneous improvement in the spastic paraplegia make it, perhaps, allowable to suggest that both were dependent on anæmia, which yielded to iron and arsenic. The action of arsenic may possibly link together several apparently widely different conditions.

I was much struck last year in watching two cases of psoriasis, both of which got quite well on arsenic, with the concurrent improvement in complexion and general health. The patches of psoriasis suggest hyperæmia of nerve-areas and (?) consequent overgrowth of skin, possibly due to some faulty "blood-condition." The curative effects of arsenic in pernicious anæmia, purpura hæmorrhagica, psoriasis, and possibly some cases of spastic paraplegia suggest one common action for the drug and community of origin for the diseases.

S. W. MacILWAINE.

A Demonstratorship in Biology is vacant.—Applications should be sent in to the Dean.

Parotitis in Typhoid.

A boy, aged 18, who had been in hospital about two months previously with typhoid, was re-admitted on January 1st, with a fresh attack. On January 8th, his right parotid became swollen and painful, and two days after, the left. Both remained in this condition for three or four days, and then subsided. The patient died on the 16th January, from the severity of the disease itself.

The complication is by no means common in typhoid, though said to be frequent in typhus fever. Of course, it is possible that the infection of mumps may have been present, but as parotitis is a known and described complication of enteric, though a rare one, the attack more probably falls under the latter heading, and into the same category as parotitis after abdominal operations.

Foreign Body in Rectum.—A case of foreign body in the ischio-rectal fossa which I have lately read, reminds me of another case in which a man with no phthisical taint, and otherwise in perfect health, came up with numerous sinuses about the ischio-rectal fossa, for which he had often been operated upon, but without success. Under an anæsthetic the sinuses were slit up, and, on exploring the rectum, an eroded piece of bone about one inch by half-inch, flat in shape, was found and removed. The sinuses then healed up perfectly.

C. C. ELLIOTT.

New Somerset Hospital, Cape Town.

Prizes.

SECOND YEAR'S STUDENTS.

First Prize of £25, awarded to Mr. H. W. Bruce.

Second Prize of £10 divided by Messrs. G. E. Richmond and F. E. Walker.

Certificate awarded to Mr. P. Turner.

FIRST YEAR'S STUDENTS.

First	Prize of £50, awarded to	Mr. C. T. Hilton.
Second	„ £25, „	Mr. G. N. Meachen.
Certificate	awarded to	Mr. J. T. Dunston.
„	„ „	Mr. F. W. Brook.
„	„ „	Mr. J. T. M. McDougall.

Guy's Hospital Dental Department.

Practice during July, 1895.

Gold Fillings	580
Plastics	682
Artificial Crowns	88
Dentures	25
Devitalized Teeth	264
Scalings	99
Regulations	11
Attendance for Extractions under Anæsthetics ...	1215
„ „ without „ ...	750
Total	3714

Passim.

A different hand this week directs the pen in these columns, and we now acutely feel the loss of one who for the period of twelve months has been the mainstay of this journal. Everyone knows of the energy of Mr. H. J. Spon, and we have all admired his whole-hearted devotion to the Gazette. Were further evidence needed, we should only point to his "Twenty-one Years of Sport at Guy's" as an earnest of his hard work and true sportsmanlike instincts. As we have said, Mr. Spon has found it necessary to relinquish his immediate active interest in this paper, and so we have to make our bow, hoping that during our time of office there will be the same hearty rush for Gazettes on alternate Saturdays, and the same healthy slangings during the following week at the contents, which, however, have no other result than a further increase of interest.

It is owing to the kindness of Mr. H. E. Durham that we this week reprint two of the late Mr. A. E. Durham's clinical lectures. As a means of surgical instruction their value is undoubted, but—far better than this—the "Old Man's" kind spirit and patient mind even now speak to us from these pages.

In the name of Guy's men in general, we take this opportunity of congratulating Dr. H. J. Campbell on his appointment as Physician to the Bradford Infirmary. On leaving us Dr. Campbell will take away good wishes mixed with regrets, as he will be much missed as an earnest and lucid teacher of Biology, and as a painstaking Secretary of the Physical Society.

Our two representatives in the Army Examination beat all the others—as is only right, and to be expected—but we are none the less proud of Messrs. Brereton and Statham, and trust they are not too weary of congratulations to receive ours.

The Physical Society, as in years gone by, will hold its opening meeting on the evening of October 1st, when Mr. De'ath will be the reader of a paper on "Our Profession, our Patients, our Public and our Press," with Dr. Wilks in the chair. The annual Dinner will take place in the Club Dining Hall, at 7 p.m., when Dr. Pye-Smith will preside. We hear that already there is some competition for seats.

To-day we publish another letter on the "Guy's Colours," the good sense of which thoroughly recommends it. We have made such enquiries as are at present possible, and have failed to find out the origin of the blue and orange, or the quantities of the two colours. Does any reader know? It appears to us that the chief people licensed to grumble at the present time are the "Blues," as a hat ribbon is being generally sold to Guy's men which only prolonged scrutiny can distinguish from the real "Blue" ribbon. Have not the "Blues Committee" the power to regulate this?

The Rules of the St. Bartholomew's College have come to hand, and we extract the following as worthy of mature thought:—

Non-resident Students may dine in the Hall, if they give notice of their intention before eleven o'clock in the morning.

No article of provision or drink shall be admitted into the establishment except with the sanction of the Warden, with the exception that Students may buy and make their own tea, coffee or cocoa, if they desire it.

We regret that owing to a clerical error the name of Mr. A. W. Ormond appeared instead of Mr. S. J. Ormond's as passing the recent Inter. Sci. Examination.

The only fixture of the Long Vacation Cricket Team ended very disastrously and has become notorious only on account of the rapidity of our opponents' scoring. Having 229 to get, Streatham made 265 in one hour and fifty minutes, to which amount Mr. N. F. Druce was the chief contributor with a grand innings of 162, which he took one hour and forty minutes to compile. For us, Stamford with 73, Alexander with 63, Harris with 33, did more than their share of the scoring.

We have been wondering why more such matches could not be arranged at this part of the season, when fairly good teams should be available, as several cricketers of former years might get away now that the Staff are having their well-earned vacations.

We hear that St. Thomas's lately asked for a match, which was unfortunately found impossible, but we feel sure that if matches were arranged another year, men would somehow manage to play, as the few such fixtures that have taken place have been marked by a keenness and *bonhomie* worth making some sacrifices for.

Revised Rules of the Debating Society.

1. This Society shall be called the "Guy's Hospital Debating Society"; and it shall be a constituent institution of the Clubs' Union.

2. The annual subscription shall be 2s. 6d. for members who joined the Hospital before October, 1891, and who are not members of the Clubs' Union. No student joining the Hospital after October, 1891, shall be admitted to the membership of the Society unless he shall have previously joined the Clubs' Union.

3. All subscribers to the Clubs' Union shall be members of the Debating Society.

4. The management of the Society shall be vested in a Committee—to be elected at the annual general meeting, which shall be held on the same night as the last meeting of the Winter Session—consisting of a President (who shall be a past or present member of the Staff), three Vice-Presidents, two Secretaries, who shall also be Treasurers, and six other Members.

5. A Committee meeting shall be called from time to time by the Secretaries; four to form a quorum.

6. The Society shall meet at least once a month during the Winter Session, on Saturday evenings.

7. Seven days' notice of any meeting shall be given; such notice to be posted on the public notice boards.

8. The meeting shall begin at 7.30 p.m., and shall terminate not later than 10 p.m., unless a majority of the house decide that the meeting be further prolonged.

9. Each Member shall be permitted to introduce one visitor, who may take part in the discussion, but shall not be allowed to vote.

10. The expression and discussion of theological views shall be absolutely prohibited.

11. The selection of subject for debate shall be left to the discretion of the Committee.

12. All speeches shall be limited to ten minutes, except those of the proposer and opposer, who shall be allowed twenty and fifteen minutes respectively, unless the house has previously granted them an extension.

13. No Member shall be allowed to speak more than once on the same evening, except at a private business meeting, and except the proposer and opposer of the proposition, the latter of whom shall be called upon by the Chairman at least ten minutes, the former at least five minutes, before the time fixed for the termination of the debate.

14. The Secretaries shall minute the proceedings of the Society at each meeting in a minute book. This book shall be open to the inspection of any member, and it shall be competent to any member to notify any omission or mistake in the report, but no correction shall be made except by the Secretary under the ruling of the Chairman when the minutes are read at the following meeting. The Secretaries shall also send a short account of each debate in time for insertion in the following issue of the Gazette.

15. In the absence of the President and Vice-President, a chairman shall be elected by the Committee from among their number.

16. The Chairman is the sole interpreter of the rules, and shall decide all questions of order. He shall interpose at meetings of the Society when there is a breach of order. He shall call on any member to explain or apologise for any expression or conduct which he may consider disorderly. All explanations shall be received without question of the real intention of the speaker, but it shall be in the power of the Chairman, after such explanation, to direct the speaker to withdraw the expression objected to. He may check any speaker whom he considers to be departing from the question, or to be introducing any theological matter. For any refusal to submit to his authority, he shall have power to suspend the offending member for the evening.

17. All speakers shall address the chair.

18. These rules shall not be in any way altered except a majority of two-thirds of those present at the meeting are in favour of the alteration. Notice of any proposed alteration of the rules must be given in writing to the Secretaries at a previous meeting.

19. The Committee shall arrange for the annual ladies' night, and also for an annual dinner of the Society, which shall be held during the Summer Session.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Colours.

SIR,—I see there is again a suggestion to change the Guy's colours. This is a question that has constantly come up as long as I have had any connection with the Hospital. Before making a change, I think it would be well to endeavour to find out why dark blue and orange were originally selected. If there was any good reason for the selection—if, for instance, they are in a sense monumental, it would be well to know the connection in which they are used, and then, if the object is found a worthy one, probably most men would wish the colours to remain as they are. It is well also to remember that many very celebrated football players have worn them. If, after inquiry, it is decided to make an alteration, then I think it would be well to proceed on certain definite grounds in making a new selection.

In the palmy days of heraldry, a knight in choosing the colours of his Lambrequin, *i.e.*, a sort of pugaree for his helm, usually was guided by the tinctures of his shield. I suggest, therefore, that Guy's athletes in choosing their new colours should take them from the Guy's coat-of-arms. The bearing of the Hospital is:—"On a field sable a chevron or, charged with three fleur de lis vert, between three leopard faces argent, crowned or." Here are plenty of colours to select from—black,

silver or white, gold and green. It would not be incorrect to use all or any of them.

Whether my suggestion is accepted or no, I think you will agree that it is worth consideration.—Yours very truly, J. H. G.

Aldershot, 14th Aug., 1895.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

J. H. D., Porth.—The growth is a sarcoma composed of interlacing bundles of large spindle-shaped cells. There is no reason for supposing that this has been caused in any way by the slight bruise of the popliteal space.

J. M. B., Burgess Hill.—*Morning*—Reaction acid, sp. gr. 1014; albumin, sugar and blood absent. Microscopic examination of the deposit shows squamous epithelial cells in abundance. Also crystals of uric acid and of the stellar phosphates. No tube casts or renal epithelium could be detected. *Night*—Reaction acid, sp. gr. 1024; albumin, blood and sugar absent. Microscopic examination shows the presence of squamous epithelial cells, and a few granular leucocytes. No renal tube casts could be detected, but crystals of calcium oxalate are present in large quantities, also a few stellar phosphates.

W. A. E. W., Rugby.—The growth consists throughout of well-developed fibrous tissue. Parts seem to have undergone irritation and consequent slight inflammation but none of it resembles any of the varieties of sarcoma.

H. H. DuB., Weymouth.—The epithelium at the spot mentioned in your letter is hypertrophied, the superficial layer ulcerated, and tending to degenerate. The connective tissue surrounding is full of inflammatory cells. None of the epithelial processes, however, appear to have passed beyond the limits of the normal epithelium, and the ulcer cannot be said to be carcinomatous.

PATHOLOGIST.

The Treasurer's Report of the Hospital

For the Year ending Lady-Day, 1895.

[A complete copy of the Report, containing List of Officers, days and hours of attendance at Out-Patients, full particulars of Special Departments, together with Financial Statement and Statistical Tables, may be obtained on application to Mr. C. H. Wells, Secretary to the Treasurer, Guy's Hospital, S.E.]

It will be observed that, both as regards matter and form, the Annual Report submitted this year differs in many respects from those which for the last eight years the Treasurer has had the honour to present to the Governors, contributors, and other friends of the Hospital. It is indeed obvious that the report of a hospital may be designed with the primary aid of attracting fresh subscribers by drawing attention in the most striking manner to its claims upon public benevolence, or on the other hand it may seek rather to retain the sympathetic interest of Governors and friends who, having convinced themselves of the substantial justice of the claims made upon them by a particular institution, are desirous, not so much to receive information in reinforcement of its demands, as to learn what changes each year brings with it, what measures of reform have been initiated, what efforts are being made by the authorities to adapt the charity they direct to the necessities of the poor and suffering, and finally in what way they are endeavouring to cope with the peculiar difficulties of administration and finance which of late years have pressed so grievously upon the managers of metropolitan hospitals.

The present needs of Guy's seem to justify an attempt to call the attention of the public more insistently to its claims, and at this crisis to enlist the support of a fresh body of subscribers. Greater prominence has therefore been given to facts with which most of the older supporters of the Hospital are already familiar. It appears, however, to the Treasurer that it is still as desirable as ever to chronicle the year's doings, both upon historical grounds and as satisfactory evidence that the Governors have not been unmindful of the necessities mposed upon them by modern developments in medicine and surgery, that they have studied to make the most economical uses of the funds entrusted to them, and that they have striven to maintain the position of Guy's in the front rank of the metropolitan hospitals and medical schools.

The number of beds in occupation is 521, three additional beds being available in the new Isolation Ward, *and one hundred beds are still closed for want of funds*. The new cases admitted in 1894 were 5,908, against 5,764 in 1893, and the total number of patients under treatment in the year was 6,325, against 6,160 in 1893. Of this number 5,275 were discharged as cured or relieved, 115 as unrelieved, and 530 died, the rest remaining in the wards on the first day of the present

year. Of the 5,908 cases enumerated, 2,057 were medical and 3,851 surgical, amongst the latter being 875 accidents. The mean residence of each medical patient was 29·6 and of each surgical patient 23·5 days, the average for both being 25·6 days—almost identically the same figure as that of last year. The mortality amongst medical patients was 15·3, and amongst surgical 4·6 per cent., and the mean mortality of both classes 8·4 per cent.

It appears, from a comparison of these results with the returns of other years printed in the Appendix, that in the year 1894 *more in-patients were treated in Guy's Hospital than in any previous year, and that the mortality amongst them was the lowest on record.* It would indeed have been impossible satisfactorily to dispose of such numbers, had it not been for the help of the Samaritan Fund, whereby no fewer than 665 cases were sent to convalescent homes. It is unnecessary in this place to enter more fully into the work of this valuable agency, as a separate Report is published explaining its scope and operation, and those interested may obtain a copy from the counting-house of the Hospital.

A larger number of out-patients were treated last year than in any previous year.

It will be observed by those familiar with the statistics of other hospitals that the number of patients attending the special departments at Guy's is exceptionally large. It may further be added that the establishment of a Dental School in 1889 made it possible for the Governors to extend the benefits of the charity to a numerous class of sufferers who had hitherto obtained but very partial relief at any of the general hospitals of the metropolis.

With regard to the income of the Hospital, little need be said in addition to what has been stated earlier in the Report, except to place on record with grateful appreciation the continued liberality of the congregation of St. Andrew's, Stoke Newington, by whom at a collection on Hospital Sunday a sum of over £104 was added to the funds of the Institution. Nor must the Treasurer omit to commemorate with sincere recognition the endowment by the Salters' Company of five beds at an annual cost of £250, and of a cot by Mr. Llewellyn Smith on behalf of the Rose and the Ring Club. As regards the Hospital Sunday Fund, it should be observed that Guy's, though standing second on the list of participating institutions as regards accommodation and number of in-patients, comes as low as twenty-third in the amount of the award made to it. It is alleged that the basis of distribution adopted many years ago by the authorities of the Fund is accountable for this anomalous result, and it may be necessary to ask for the reconsideration of an arrangement so manifestly unsuited to the altered conditions of the present day. It will be noticed that this year a sum of £62 18s. has been derived from collecting boxes. These are the boxes placed in the wards, the contents of which were formerly devoted to the Samaritan Fund. Since, however, that Fund has been enriched by the Spicer bequest, it has been thought that the contributions from the wards might more expediently be applied to the use of the Hospital. The boxes have been labelled accordingly, and there is an increase of about £8 in the sum obtained from them since the change was made on the 1st of January, 1894.

The receipts from lady pupils' fees, paying patients, and out-patients this year are £5,848, against £5,288 in 1893, and there is thus an increase of £580 under this head. There is also some increase in rental; but in spite of these slight improvements, the fact remains that, in order to meet the current expenses of the Hospital, it has been necessary to take no less than £15,940 from the Special Appeal Fund, which has now shrunk to about £18,000 (subject to liabilities of over £8,700), leaving a sum barely sufficient to meet disbursements up to the end of the present year.

During the past twelve months very considerable economies have been effected under the items of "Provisions" and "Surgery and Dispensary." A saving of £738 and £544 under these headings has reduced the average cost per occupied bed by £3 11s. 8d. and £1 8s. 0d. respectively. Domestic expenses show a slight increase, whilst establishment charges have risen from £5,068 to £6,624, the increase being upon ordinary repairs, and upon rates and taxes. On salaries, wages, etc., there is an increase of £500, and on administration of £422. Building improvements under the head of "Extraordinary Expenditure" have cost £2,559, against £2,196 in 1893, and the total expenditure for the year ending Lady Day, 1895, has been £43,216 16s. 8d., as against £41,659 in the previous year. Those who are interested in the study of comparative statistics will find a detailed analysis in the tables printed as an Appendix to this Report.

During the past year three of the Governors of Guy's have been removed by death—Lord Coleridge, Lord Justice Bowen, and Mr. Joshua Butterworth. The last-named Governor was a very regular attendant at the meetings of the Court, and interested himself particularly in the welfare of the Sisters and Nurses of the Institution. Only last year the Treasurer had to allude to his kindness in procuring pictures for the decoration of the Nurses' Sick Room, and several years ago Mr. Butterworth invested with the Charity Commissioners a sum sufficient to produce an annual income of £6, to be spent on silver medals for the nursing staff. The medal bears upon the obverse a medallion with the inscription, "Thomas Guy, Founder of Guy's Hospital, 1720," and on the reverse, "Medal instituted by Joshua W. Butterworth, F.S.A., a Governor. To [*space for name*] Certificated Nurse, on completing five years' service."

The relatives of Canon Cazenove have erected a brass to his memory in the chapel of the Hospital with the following inscription:—

> To the glory of God, and in memory of
> REV. ARTHUR CAZENOVE,
> Who died 10th August, 1893. Youngest son of the late PHILIP CAZENOVE, both of whom were Governors of this Hospital, and much interested in its welfare.

They have also invested with the Governors the sum of £150, the interest upon which is applied annually to

provide prizes for those Nurses who are most successful in the examinations in nursing, and in medicine and surgery as applied to nursing. These prizes, known as the Cazenove Prizes, take the form of a course of free instruction in dispensing, and occasion keen competition amongst the probationers of the Hospital.

Last year the Treasurer had to record the retirement by lapse of time of Mr. Arthur E. Durham from the post of Senior Surgeon, and although Mr. Durham's death has occurred this year later than the period properly included in this Report, the Treasurer ventures to direct attention to the movement which has been set on foot to endow two beds in the Hospital to his memory at a cost of £2,000. As showing his own feelings, the Treasurer may be permitted to quote from a letter lately addressed by himself, in association with the Senior Physician and Senior Surgeon of the Hospital, to old Guy's men and to other friends of the deceased. The words are as follows:—

"In appealing to all Guy's men and to other friends towards this worthy object it is needless to dwell upon the manifold services Mr. Durham rendered to Guy's as a teacher and surgeon of the first rank, upon the unaffected kindness of his disposition, and upon those genial traits of character which endeared him to all who had the privilege of knowing him." It is gratifying to be able to add that at the time of going to press with this Report, the sum already subscribed reaches nearly £1,500.

Miss Loag, a former Matron, and Miss Marsh, a former Linen Store Keeper of the Hospital, died within a few days of each other at the end of last February. They were in receipt of pensions of £150 and £75 respectively, for long and meritorious service. During the past year Nurse Newman, who had reached an advanced age in the employment of the Hospital, was pensioned with £26 a year, and W. Hunt, the Plumber, who was sixty-six years of age, and had been at Guy's for twenty-two years, retired upon an allowance of ten shillings a week.

In the Steward's Department it is satisfactory to record that there has been a substantial reduction in every item, except one, coming under the head of "Provisions." In fact, although the improved dietary for Nurses alluded to in the last Report comes into this year's account, and although the daily average of patients in residence has been five in excess of the previous year, a saving has been effected of not less than £738. There is, however, an increase of £240 under "Coals and Lighting," £150 of this sum being accounted for by a special grant made by the Court to the contractors, Messrs. Gowland and Co., who, though hampered by serious difficulties during the great coal strike of 1893, continued to supply the Hospital with no advance upon the contract prices, and with such commendable regularity that the patients did not suffer in the prevalent scarcity. The laundry has cost £36 less than in the preceding year, and this result may be regarded as very satisfactory. On the other hand, "Renewal of Furniture," shows an increase of £206, and "Hardware, crockery, etc." a decrease of £60. A like sum has been saved in water, the total under "Domestic Expenses" showing an increase of £326.

At the beginning of the last financial year the Treasurer initiated a new system for the supply of drugs and surgical dressings by open contract. Recognising, moreover, the well-known obstacles in the way of economy presented by the constant changes in the resident staff of House-Physicians and House-Surgeons which must necessarily take place in a Hospital to which a Medical School is attached, he sought to overcome such difficulties as far as possible by circulating amongst the medical, surgical, and nursing staff, full information as to the dressings and drugs employed, and as to the relative quantities of the former consumed in the various wards. Accordingly, at the end of every three months a report is submitted by the Head Dispenser to the Treasurer, in which attention is directed to any drug or preparation which is particularly expensive or is being employed in exceptional quantities, and in the report is stated the name of the Physician or Surgeon by whom it has been ordered. This Dispensary report is submitted quarterly to the medical and surgical staff for their consideration and comment, and many valuable suggestions tending to economy have been received from them. As regards surgical dressings the plan adopted is somewhat different. Of them a monthly return is prepared in the Dispensary, giving the prices of the various articles and the amount consumed of each in yards, pounds, or otherwise as the case may be, these quantities being worked out at the contract prices, and the total for each ward shown in pounds, shillings, and pence. The dressing returns are circulated, together with a statement of the average number of patients in daily residence in each ward, amongst the Physicians, Surgeons, House-Physicians, House-Surgeons, Matron, and Sisters, who are thus put in a position to ascertain how they stand in comparison with wards of similar size and character. The stimulus to economy thus applied, together with the adoption of a new system of contract, has resulted this year, as compared with last, in a saving of no less than £448 upon drugs, chemicals, and disinfectants, and of £304 upon bandages and dressings. And this result has been accomplished, notwithstanding that 228 more surgical patients were treated in the wards than in the previous year, and that the number of out-patient attendances has so largely increased that the sum received in out-patient payments is £55 in excess of that shown in the accounts for 1893. About £60 more has been spent this year upon instruments and appliances, and £10 less upon ice and mineral waters. The items of the latter account are as follows:—Carbonic acid gas, £14 10s., repairs of machine, £1 5s. 3d., repairs and replacement of syphons, £1 9s., total, £17 4s. 3d. The consumption of soda water and lemonade throughout the year has been 23,033 syphons, the lowest number used in a week being 321 in January, and the highest 698 in July. Taking the items under "Surgery and Dispensary" as a whole, the account year shows a saving of £544 over the

previous year, and this result the Treasurer regards as very satisfactory.

The Washington-Lyon Disinfector is now used for sterilising surgical dressings on a large scale, and if such aseptic dressings should commend themselves to the majority of the surgical staff, considerable economies might still be possible in this very important branch of Hospital expenditure.

The popularity of Guy's as a training school for nurses appears to be well maintained, about 3,000 applications having been received this year by the Matron from persons desirous of obtaining information as to the nursing arrangements. Last year the Treasurer alluded to the improvement in the Nurses' dietary which he has been able to effect with little or no additional cost to the Hospital. The health of the Nurses has been very good, the Sick Room being often unoccupied for weeks together. A new scale for holidays has been arranged by the Matron, in accordance with which a Probationer at the end of her first year of training has two weeks, at the end of two years three weeks, and at the end of three years four weeks, and thenceforward four weeks holiday in the twelve months. To increase the comfort of the nursing staff when off duty, the sitting-rooms for Nurses and Probationers have been refurnished, and they appear to be much appreciated. By permission of the Council of the Clubs' Union, the upper tennis courts at the Recreation Ground have lately been reserved on three mornings of the week for the use of the Night Nurses, and the London and Brighton Railway Company has granted to Nurses the privilege enjoyed by other members of the Club of obtaining cheap return tickets from London Bridge to Honor Oak Park station. A tennis club has been formed amongst the Nurses, under the patronage of the wives of some of the Governors and Medical Staff, and the facilities for healthy recreation and exercise thus afforded are greatly appreciated. Washing uniforms have been introduced for the Sisters and Lady Pupils, the alpaca of the latter uniform being replaced by a small black and white check in linen. Spring beds have been provided for the Sisters throughout the Hospital, and a bathroom constructed for them in the Surgical Building. The Assistant Matron has been given a furnished sitting-room in a situation convenient for her duties, and the Housekeeper's room has been repainted and its furniture renewed.

The Treasurer is glad to observe that every year an increasing number of Sisters and Nurses are availing themselves of the benefits of the Royal National Pension Fund for Nurses, to which he has previously invited attention. Mr. Burdett's projected publication of a Nursing Directory, for the protection of the public and the benefit of the nursing profession, has his warm approval, and will, he trusts, speedily be conducted to a successful issue.

The dietary of the patients has been modified by the substitution of roast beef for mutton on Wednesdays. The Sisters assure the Treasurer that the change is very popular, particularly amongst those patients who, staying long in the Hospital, find cold roast beef on Sundays an insufficient break to the monotony of roast or boiled mutton on the other days of the week. Smoking has been allowed in the wards on all Bank Holidays, and not, as heretofore, confined to Christmas Day. For the pillows of the beds the woollen flock used for stuffing has been in great part replaced by a much softer material which is left as a waste product in the manufacture of silk. This flock, being of the nature of silk, does not become matted like wool, and what is of still greater importance, it can be submitted to the action of superheated steam for purposes of disinfection without becoming hard and uncomfortable. For the protection of patients and nurses the antiseptic solutions used in the wards have been coloured, the carbolic with magenta, the mercurial lotion with aniline blue. In Bright ward the cooking arrangements have been so modified that patients who can take ordinary food have the advantage of the greater variety afforded by a choice amongst any of the dishes provided for the Students' Club, and the central hall of the ward is free from that smell of cooking which at times was formerly so unpleasant. To facilitate the transmission of messages and the summoning of the Resident Medical Officer a telephone has been established between Bright ward and the College.

In the Out-Patient Department several changes have to be recorded. To enable the Ophthalmic Surgeons to cope with the increase of work which the popularity of their department brings with it, a second Ophthalmic Assistant has been appointed, and the necessary arrangements have been made for his accommodation. In the Dental Department the Conservation Room has been placed in charge of a lady clerk, and the plan is generally admitted to have proved eminently successful.

It will be remarked that during the past year no less a sum than £4,660 has been spent on "Repairs Ordinary," and £2,559 upon building improvements under the head of "Extraordinary Expenditure," an excess in all of £819 over the year 1893–4. Some of this money has been laid out upon the various improvements already related in the Report. Amongst the most important, however, still to be reviewed may be mentioned the completion of the great work of improving the drainage and sanitary arrangements of the east wing of the surgical building. This task, which was one of unusual difficulty and complexity, was very ably carried out by Mr. Chapman, the Clerk of the Works, under the superintendence of the Surveyor of the Hospital, and the occupation of the wards suffered no interruption. The scheme has furnished the five wards concerned with new kitchens and bathrooms (the latter with a separate hot-water supply, each from the ward to which it is attached), and by the provision of cross ventilation, new closets, sluices, and otherwise, it has brought the sanitation of the building up to the level of modern requirements. Exigencies of space have rendered it impossible to give all the room to these appurtenances that might have been desired, but nevertheless the result appears to meet

with general approval. From first to last the work has cost about £2,000.

Another improvement alluded to in last year's Report has now been completed, namely, the raising of the level of the paths in the "Park" by placing upon them the ashes and clinker produced from the destructor furnace. The appearance of the ground has been much improved thereby, and no cost has been incurred except for labour.

In the early part of the year, it was found that the large iron smoke-extraction flue in the old wing of Hunt's House was defective, the packing between the flanges of the tube having perished, and thus there was a chance that a fire might occur if from any cause the soot should become ignited. Accordingly the joints were made good under the supervision of Mr. Kirkland acting as Engineer for the Hospital. The drainage of Hunt's House has also required the expenditure of much money upon it, and the work is still incomplete. In the sanitary block at the south end of the building, the soil pipes were carried inside the structure opening into a dip-trap, and there was no cross ventilation. The closets, too, were of old type, and the time had clearly arrived when it was necessary for the drainage to be overhauled. So far as the more important defects are concerned, this has now been done, but something still remains to do before the arrangements can be regarded as satisfactory. Good sanitary work is always expensive, but notwithstanding the straitened condition of the Hospital revenues, the Treasurer has not thought fit to close wards during its progress. The saving thus effected would no doubt have paid much of the cost connected with the alteration, but it would have been at the expense of the sick and suffering for whom the Hospital exists. The excavation made for laying the new drain at the south end of Hunt's House gave an opportunity of underpinning the walls of the Ophthalmic Rooms in the Out-Patient Department; and as this proceeding would in any case have shortly been necessary for the stability of the structure, it was fortunate that it should be undertaken at the same time as the drainage work, one excavation thus serving for both purposes.

Cases of infectious disease are continually brought to the Hospital, and in a previous Report the Treasurer mentioned that he had provided an isolation room for them, pending their removal to the hospitals of the Metropolitan Asylums Board. It occasionally happens that scarlet fever or other infectious disease attacks a patient already in the Hospital whose condition is such as not to permit of his removal, and such cases have hitherto been nursed in one of the disused wards. This arrangement, however, is an uncomfortable one both for patient and attendants, and therefore the Treasurer has recently provided an isolation ward, converting to this purpose the room formerly known as the Splint Room. The new ward is lined partly with white glazed bricks and in part by Keen's cement, painted and varnished, and in close proximity to it is the old "Strong Room," which, not now being required for delirious noisy patients, is available for isolating the special nurses employed to nurse the cases placed in the new ward.

In continuation of the work begun in 1893, the Treasurer has during the past year endeavoured to promote economy in the water-supply of the Hospital, in fuel, and in the laundry department. He has lately concluded an agreement with the Vestry of St. George-the-Martyr, whereby a sum of £20 per annum is paid by them for the privilege of destroying infected articles in the destructor furnace mentioned in the last Report. With the object of saving coal, a Green's Economiser has been placed in the flue of the furnaces, and by this arrangement the water, circulating in a series of upright tubes, is heated to about 240° F. before being delivered into the laundry, and this without the use of any more fuel than heretofore, the work being done by the heated gases which escape from the furnaces on their way to the chimney shaft. From this economiser the Clinical wards are now supplied with hot water for heating and for baths, etc. Formerly steam from the boilers was used for this purpose, and the new method is therefore more economical, and is found in practice to be more convenient.

It will be remembered that the Hospital possesses an artesian well on the drying ground of the laundry, and that the water from this well is pumped by a steam engine into a cistern placed at the top of the central staircase of Hunt's House. Unfortunately, for many years the yield from this well has had to be supplemented from the mains of the Southwark and Vauxhall Water Company, and every year the Hospital pays about £250 for this auxiliary supply. Hence, after a careful trial to determine whether it would be sufficient for the needs of the Hospital, the Treasurer decided to make use of a supply obtainable from an old well existing in front of Petersham Buildings. The water was, of course, unsuitable for drinking purposes, but being clear and without smell or taste, it seemed very well adapted for use in the water-closets of the Hospital. Recognising, however, the danger, unless special precautions were taken, of contaminating the drinking water with this water intended for other uses, the Treasurer obtained the approval of the Governors to the construction of a separate cistern on the north-west tower of the Medical Building, and the equipment of a Worthington pump in the engine-house close to the laundry. The new cistern and pump are employed exclusively for the purpose mentioned, and from the cistern new lead pipes have been taken, forming an entirely separate service to the water-closets of the Hospital. Water from the same source has enabled the Treasurer to set in action a long disused fountain in the Park, the basin of which has been fenced with an iron railing to avoid accidents, and stocked with gold-fish and aquatic plants.

It will be readily understood that in a large institution such as Guy's Hospital, with between four and five hundred patients in daily residence, and a staff of nursing and other officials about a hundred and fifty in number, the Laundry is one of the most important

departments under the charge of the Matron. It is indeed obvious that the proper washing of the linen used in the wards and elsewhere is of the greatest importance to the well-being of the inmates, and that failure in this respect may be attended with very serious results to those whose condition of bodily health renders them peculiarly susceptible to the influence of infectious disease. The Laundry has therefore, from time to time, claimed and received from those in authority much anxious attention; and, as the demands upon its resources have gradually increased, various labour-saving machines, driven by steam-power, have been introduced to enable the staff to support the heavier burden imposed upon them by the requirements of modern hygiene.

As regards construction, machinery, and appliances, the Laundry of Guy's Hospital may be considered to be well equipped, but for a long time past much difficulty has been experienced in obtaining the services of suitable women to undertake the work. Complaints have constantly been made by Sisters and Nurses of the way in which the washing has been done, and of numerous thefts, which have been rendered exceedingly difficult of detection from the facility with which dishonest washerwomen are able, on leaving the Hospital in the evening, to convey stolen property to their homes in the Borough. It is enough to say that for the last ten years, linen, blankets, &c., have been missing from the Laundry to the amount of about £100 per annum. Vigorous attempts have been made to cope with these and other difficulties, nor have there been wanting honest, sober, and industrious women, whose work in the Laundry has been all that could be desired; nevertheless, those familiar with the neighbourhood whence the laundresses are drawn will not find it hard to believe that an adequate supply of suitable women is rarely to be obtained.

Compelled, therefore, to seek some remedy for this very unsatisfactory state of things, the Treasurer determined that the staff of the Laundry, instead of residing outside, should live within the precincts of the Hospital, in a house which should be under the supervision of a competent mistress. Such a plan would, he thought, render impossible much of the thieving which has caused such serious loss to the Institution, and, what was of even greater importance, would make it practicable to place the women engaged under better influences, and thus to raise the standard of life and conduct amongst them. Fortunately, at a time when the pressure of the situation was becoming intolerable, an opportunity presented itself of acquiring, at a reasonable outlay, a building lying immediately outside the Hospital boundary, and, as regards size and position, everything that could be desired for a Laundresses' Home. The building, purchased for the sum of £2,100, has been converted into a LAUNDRY HOSTEL, at a further cost of about £1,500, in accordance with the plans of Mr. J. H. T. Woodd, the Surveyor to the Hospital; the hot-water and heating apparatus being designed by Mr. T. Kirkland, Engineer of 17, Victoria Street, Westminster.

The Hostel stands upon a site in the Old King's Head Yard, from which it has its principal entrance, and there is a second door opening directly from the Hospital. The ground floor is occupied by a large recreation-room, for use in the evening, by the Mistress's sitting-room, and by the heating-chamber. On the first floor is the dining-room, with serving-room, lavatory, bathroom, and the smaller dormitory having five cubicles overlooked from the Mistress's bedroom. On the second floor is the large dormitory, divided into thirteen cubicles, with the Head Laundress's bedroom, a lavatory, and bathroom. At the top of the building are the kitchen, scullery, larder, etc., together with several small bedrooms. An outside lift conveys coals and provisions up to the kitchen, and there is a second lift between the kitchen and dining-room beneath.

To those acquainted with hospital work it is a matter of common experience how difficult it is to find suitable employment for young women who, more often from ignorance than deliberate intention, have fallen out of the way of right living. After coming under the spiritual influences brought to bear on them in the wards, such girls are frequently desirous of leading a higher life, but when the time comes that they are well enough to be discharged from the Hospital, they find almost all the avenues of honest employment closed against them. It was upon the ground that such cases are peculiarly fit subjects for the charity of the Samaritan Fund, that the Treasurer gained the consent of the trustees of the Spicer bequest to the proposal to use some of the money in their hands upon the purchase of the Hostel, interest upon the capital thus expended being guaranteed by the Hospital, and such interest being applied in accordance with the terms of the legacy for the relief of convalescent patients on their discharge. In this way both capital and interest are made available for the good of those whom Mr. Henry Spicer designed by his will to benefit.

The Laundry Hostel was opened by the Bishop of Rochester on the 28th June, 1894, and the Treasurer is glad to say that, under the careful management of the Matron and Miss Evans, the scheme has proved eminently successful in every sense. Not only has the washing for the Hospital cost less money, but it has been better done. Moreover, the losses from the laundry, which, as stated above, used formerly to average £100 annually, have practically ceased. In fact, it is not too much to say that the establishment of the Hostel and the better method of management thereby rendered practicable have been of the highest moral and material advantage to all concerned.

In conclusion, the Treasurer, whilst apologising for the unusual length to which his observations have run, ventures to express the opinion that the items of which they are composed deserve to be included in the chronicles of the important Hospital which he represents, and he trusts that a perusal of this Report may show to those interested in such matters that the Governors of

Guy's Hospital are striving, so far as in them lies, efficiently and economically to administer the great Institution committed to their charge.

ED. H. LUSHINGTON, Treasurer,

The Counting House, Guy's Hospital,
August, 1895.

PUBLIC APPEAL.

The Governors of Guy's Hospital regret that they find themselves under the necessity of appealing for aid to the benevolent, and in doing so think it right to lay before the public a statement of the financial position of the Institution.

The Hospital was founded under the Will of Thomas Guy in 1724, and in that Will a proviso was made by the Founder that the funds with which he was endowing the Hospital should be invested in land only. From that time the revenues of the Hospital continued to increase, until the year 1880, when the net rentals from land in Essex, Herefordshire and Lincolnshire, available for Hospital purposes, amounted to £40,000 per annum. The Governing Body, ever anxious that the Hospital should be of the greatest service to the neighbourhood, gradually erected and continually improved the fabric and appliances of the Hospital *pari passu* with the increasing rental, until in 1880 the Governors were able to point to a large, well-built Hospital, situated in the south-east of London, provided with every requisite, officered by a whole school of professional and nursing talent, having 600 available beds, and ministering effectively to the public service.

Since 1880 the continued fall in the value of land has brought disastrous results to the finances of the Hospital, and has unfortunately frustrated the charitable intentions of Thomas Guy.

The net annual income from its landed property has fallen from £40,000 in 1880 to about £20,000 in 1894.

In 1885 the Governors endeavoured to meet this deficiency in income by closing some of the wards, but the loss becoming so serious, in 1886 a special appeal was made to the public.

In answer to this appeal something over £100,000 was generously given, and this has sufficed to maintain the Hospital for the last nine years, and to enable it to continue its work in unimpaired and even increased efficiency.

Of the £100,000 there remains now only sufficient to carry on the Hospital for some months.

The greatest economy is practised, and the Governing Body are proud to be able to state that the actual cost per bed occupied is slightly below that of most of the great London hospitals; and that this result has been attained without in any way impairing the comfort of the patients or the efficiency of the treatment.

The conditions under which it will be possible to continue the maintenance of the Hospital now press for consideration and settlement.

The deficiency in income cannot well be met by reducing the expenses of the management, or by closing wards, consistently with carrying out the duties of the Medical Staff to the patients or those of the Hospital towards satisfying the demands of the neighbourhood.

The latter, indeed, rather show a tendency to increase in number. In the past year 5,908 new cases were admitted, against 5,764 in the previous year, and of this number 5,275 were discharged as cured or relieved.

The annual expenditure amounts to		£40,000
The assured income is about	£20,000	
Income from other uncertain sources	6,000	
		26,000
Annual deficiency		£14,000

Unless this sum is forthcoming one year with another, there appears to be no alternative except to make such a general curtailment of the work of the Hospital as would seriously cripple its utility to the public.

It is unnecessary to enlarge on the suffering that such a measure would entail on the poor of south-east London.

The district is probably the most destitute in the Metropolis, and Guy's is the only hospital available for its needs.

Moreover, the benefits conferred by Guy's are by no means limited to the district in which the Hospital is located.

Patients from many parts of England, whose cases require treatment not available at their own homes, are frequently sent up to Guy's, and return in many cases benefited or cured.

It is thought advisable to explain these difficulties in the hope that charitable persons will assist the Governing Body of the Hospital by placing it on a sound footing, so that Guy's, like other London hospitals, shall be able *to count on an assured income from Annual Subscriptions* and Donations sufficient, with its remaining endowment, to maintain the establishment on the same scale as heretofore.

Moreover, if the charitable public can be brought to realise that the so-called endowment of Guy's means the annual deficit of £14,000 a year, an increased number of legacies may fairly be anticipated as likely to accrue to the Hospital, a source of income which is found in many similar cases to be an item of regular and considerable amount.

The Hospital is open, upon application, to visitors, and the Governors are confident that those availing themselves of such permission will be satisfied with the devotion of the Medical and Surgical Staff, and with the care and assiduity of the Nurses.

Letters of Recommendation for patients of the Hospital will be placed at the disposal of all Donors and Subscribers in proportion to the amount of their subscriptions, and they will also continue to receive the Annual Report of the Treasurer, with the Balance Sheet and Accounts of the Institution.

The names of benefactors will be recorded on a roll, from which future Governors would (as a general rule) be preferentially selected.

HENRY H. GIBBS, President.

ED. H. LUSHINGTON, Treasurer.

Note.—Contributions will be gratefully received by the Treasurer, at the Hospital; or may be sent to the Bankers, Lloyds Bank, Limited, 72, Lombard Street, E.C.

Privileges of Subscribers.

A donation of not less than Thirty Guineas in one sum, or an Annual Subscription of Five Guineas, entitles the contributor to fifteen Letters of Recommendation yearly.

Contributors are entitled to receive three Letters of Recommendation for each Guinea subscribed, whether directly by themselves or otherwise.

It must be understood that the Hospital is intended for the benefit of those who, not being in receipt of Poor Law relief, are unable to pay for the services of competent doctors, or who, having paid according to their means for medical treatment, are desirous of further advice, or who bring with them a note from their regular doctor recommending them to the Hospital. Contributors are therefore earnestly invited to co-operate with the Governors in repressing any abuse of the Hospital by refusing Letters of Recommendation to those who do not fall under the above categories.

Those who desire Letters of Recommendation in return for their donations or subscriptions should apply for the same to Mr. C. H. Wells, Secretary to the Treasurer, Guy's Hospital, London, S.E.

A person applying with a Subscriber's Letter is treated as an in or out-patient at the discretion of the Medical and Surgical Staff, and as the accommodation available at the time in the Hospital may allow. A Letter is available for eight weeks' attendance in the Out-Patient Department, if the physician or surgeon under whose care the patient is placed considers so long an attendance to be required. At the expiration of eight weeks from the time at which the patient first came under treatment, a fresh Letter must be obtained, if attendance is to be continued.

The Governors are always glad to receive presents of flowers, whether cut or in pots, and of plants to brighten the wards. Old linen is useful for dressings. Clothes of all sizes for the benefit of destitute patients on their discharge from the Hospital are very acceptable, and the Matron will be glad to hear of any ladies who may be willing to make garments for deserving cases, the materials being supplied either by themselves, or through the Samaritan Fund for the Relief of Convalescents.

Amongst other things which contribute to the amusement and comfort of the inmates may be enumerated: Picture books, dolls, toys, scrap books, illustrated papers, magazines (unbound), water beds and pillows, wheel chairs, invalid couches, and crutches.

Legacies.

For the guidance of those who may wish to leave a legacy to Guy's Hospital, and for the avoidance of doubt and litigation, it may be well to state that the Governors of Guy's Hospital are incorporated under special Act of Parliament as "The President and Governors of the Hospital founded at the sole costs and charges of Thomas Guy, Esquire." A legal form of bequest will be sent on application to the Treasurer. Executors may exercise the same privileges as would have belonged to the testator had the bequest to the Hospital taken effect during his life.

Endowment of Beds.

A legacy or donation of £1,000 endows a bed in perpetuity. The beds at present thus endowed are the following:—

No. 23 Mary Ward by A. P. in memory of his wife.

,, 26, 27 ,, by the Eason Bequest.

A yearly subscription of £50 endows a bed so long as the subscription is maintained. Five beds are thus endowed by the Salters' Company.

Endowment of Cots.

A legacy or donation of £500 endows a cot in perpetuity. At present no cot is thus endowed.

A yearly subscription of £25 endows a cot so long as the subscription is continued. One cot in Stephen Ward is thus supported by the Rose and the Ring Club.

If desired, endowed beds and cots are indicated in the wards by a tablet, brass plate, or otherwise.

Mental Physiology for M.D., M.S. Lond.

A Course of Lectures on "Mental Physiology, especially in its relation to Mental Disorder," supplemented by Practical Laboratory Instruction and by Clinical Demonstrations, will be given by Dr. Savage and Dr. Rivers, at Guy's and Bethlem Hospitals.

The course, which is adapted to the requirements of Candidates for the M.D., M.S. Lond., will be held during the months of October and November and a part of December. By permission of the Governors of Bethlem Royal Hospital, St. George's Road, S.E., the Clinical Demonstrations will be given at that Institution on Tuesdays and Fridays at 2 p.m. The Lectures and Laboratory work will take place at Guy's Hospital on Mondays at 2 o'clock. An Introductory Lecture will be delivered on Thursday, October 3rd, in the Chemical Theatre.

This Course is free to Guy's men.

July 15th, 1895.

Army Medical Examination.

August, 1895.

Mr. F. S. Brereton, First on List with 2,685 marks.

Mr. C. B. Statham, Second on List with 2,324 marks.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette.

SEPTEMBER 14, 1895.

The Future of Guy's.

FOR Metropolitan Hospitals to be in want of funds to carry on their never-ending, ever-increasing, and often thankless labours, has become such a matter of course, that it would be absurdly sanguine to assume that any appeal, however strong or necessary, will hold the public attention. But while this is the case with the outside world, we cherish the belief that any voice from Guy's Hospital is listened to by Guy's men throughout the world; and we cannot doubt but that the Report of the Hospital and the appeal for financial aid which was published in our last issue, has received the earnest and sympathetic attention of the readers of this journal. The plain facts are too painfully eloquent to need embellishment. Agricultural depression means ruin to Guy's Hospital unless some twenty thousand pounds per annum are forthcoming from fresh sources to supply the deficiency in income. The case is peculiarly hard, because until recent years we have been so happily independent of public support, that we have never learnt to beg, and, therefore, the benevolent have never been educated to give to this Institution, so that it will be difficult work to impress the public imagination with our necessitous condition, or, on their merits, the irresistible claims which Guy's Hospital has upon those on whom health or wealth places responsibilities. Still, the task has to be accomplished unless the greatest centre for the relief of human suffering, the truest citadel of social order in South-East London is to be reduced to a shadow of its former self, and one of the foremost medical schools in the world involved in the catastrophe. For such a waste to occur would be worse than a mistake—it would be a crime. We can but trust that the general good sense of the community will declare that Guy's Hospital must be conserved, not only for the reason that it will be cheaper to do this than to establish the new institutions which public safety would demand to supply its place, but because an atmosphere of scientific learning and teaching power, the growth of long years of accumulated experience, once dispersed, can no more be restored at will than can the lawn of an Oxford College be obtained from a single sowing of grass-seed.

There are two possibilities of obtaining the fresh income required, either that a capital amount of at least half-a-million sterling should be forthcoming for immediate investment, and so replenish the original endowment, or that subscriptions, donations and legacies to the amount required should be annually raised. In the absence of the former, the Treasurer and Governors are moving on the lines of the latter alternative. In this work the GAZETTE is deeply interested, as it is of vital importance to the well-being of the Medical School that the wards of the Hospital should be fully occupied.

It is a well-known fact that other Hospitals have been considerably enriched by the influence which their old students have exercised upon patients and friends, and if every old Guy's man will take pains to improve any occasion for saying a word for the old place, we have no fear for the result. There are many other ways also in which both past and present students might turn money into the empty coffers; but whatever the method adopted we shall be grateful, and we know there are many to whom it will be a pleasure to do what they can.

Our readers will not suppose us to be suggesting that the burden of raising this money is to fall on them alone; but they will remember that any appeal through these columns can only reach our friends. To those who have such close ties to Guy's Hospital it would be an insult to address the arguments that will be required in appealing to the general public; but we do not despair that those responsible for raising the sustentation fund will be able to persuade the Nineteenth Century that having for so long partaken of the charity of a previous generation, it in turn has a noble duty to perform.

Sarcomata.

CLINICAL LECTURE BY MR. DUNN.

GENTLEMEN,—I have recently had under my care in Guy's Hospital three cases of Sarcoma, which I propose to recount to you this afternoon. Two of these attacked bones, and the third the testicle. The first case was that of a little girl, Nora P., æt. 11 years. The growth was situated in the lower jaw, and was of the variety known as central sarcoma, since it commenced in the interior of the bone. I had to remove almost the entire left half of the lower jaw in order to thoroughly extirpate the disease. My dresser will now bring in the patient, and when you look at her full face you can notice some flattening of the left side of the cheek, but you perceive also that the nose and the chin are in the same vertical line. When you look at the side view you can see a linear cicatrix, which is well concealed by the hat ribbons. Other than this you would hardly be aware that so extensive an operation had taken place. As a rule, when a large portion of the lower jaw is removed the muscles of the sound side push the chin right over to the injured side, and hence produce a very unsightly deformity. The happy result in the present case is due to the skill of my friend and colleague, Mr. Newland-Pedley, who fitted into the upper jaw this ingenious plate, which possesses a flange, projecting from its under aspect, outside which the molars and bicuspids of the lower jaw are placed, and thus the chin is retained in its normal position. It causes her no discomfort; she opens and closes her mouth with ease, and can readily take out the plate when she wishes. I will now read the report of the case.

Nora P., æt. 11 years, was admitted into Martha ward on March 5th, 1895, for a swelling of the left side of the lower jaw. There is some history of swellings about the face in both the patient's grandfathers, but all the family living are well.

History of present affection.—Two years ago patient had a swelling inside her mouth, on the left half of the lower jaw, which burst of its own accord, but no matter has since come away. The swelling subsided considerably at the time, but soon again began to increase in size, and has been slowly increasing up to six weeks ago, when it began to enlarge more rapidly. This continuing, she went to see a doctor on February 30th, who, on her second visit four days later, advised her to go at once to Guy's, so marked had been the increase of growth during that time.

On admission.—There is a swelling at the angle of the jaw extending upward to the level of

the external auditory meatus. It measures three inches in the vertical and two inches in the antero-posterior diameter. It has a well-defined outline. The skin over it is quite normal, and shows no signs of inflammation. On palpation the surface is found to be slightly lobulated and of bony hardness, except at the anterior part, which seems to be slightly elastic. There is no egg-shell crackling and no soft spots anywhere. The skin over it is freely movable, but the mass is firmly fixed to the jaw. The swelling, which is neither tender nor painful, extends right through the jaw, involving the alveolar border, and protrudes on the inner surface of both angle and ramus. Its measurement from the interior of the mouth outwards is two inches. There is no ulceration of, or abnormal discharge from the mucous membrane of the mouth, but that covering the mass is slightly raised into a callous pad, due to the impact of the second molar of the upper jaw, and gives the appearance of a tooth about to be erupted.

Upon carefully inspecting the teeth, it is found that, although she is but 11 years old, she has cut all her second molars, with the exception of that on the left side of the lower jaw. The teeth on this side of the lower jaw are all crowded together, so that the canine is displaced forwards, and the first bicuspid nearly meets the lateral incisor behind it. No permanent teeth have been extracted.

On March 10th, having previously had a cast of the jaw taken, an exploratory incision was made, under chloroform, behind the angle of the jaw, about an inch and a half in length. The bone was exposed, and when perforated, by means of a gouge, was found to be a thin shell, covering a soft, vascular growth, through which a few bony trabeculæ passed. The aperture in the growth was plugged, and the incision was prolonged upwards and downwards to the extent of about six inches altogether. The facial artery was twisted, and the muscles attached to the jaw were dissected off the bone, both on the inner and outer surfaces. It was then found that the growth reached from the sigmoid notch down to the second left lower bicuspid. This tooth, as well as the one behind, was then extracted, and the jaw sawn through just in front of the mental foramen. The fragment was then depressed, and the temporal and external pterygoid muscles detached, after which the condyle was readily dislocated. The rent in the mucous membrane was carefully closed with a fine continuous silk suture, and after thoroughly washing the wound out with carbolic lotion, the skin was adjusted by means of several points of interrupted fishing-gut sutures, dusted with Iodoform, and dressed with blue gauze.

On section after removal, the mass was found to be formed of a thin shell of bone, with thin bony trabeculæ extending from one side to the other, and enclosing in the spaces thus formed a semi-solid red mass, which, on microscopical examination, was found to consist chiefly of small spindle cells. The missing tooth was found projecting from the inner wall of the growth, its crown having perforated the thin bony shell. The patient made an uninterrupted recovery, and was discharged on April 3rd.

The diagnosis of this case was difficult. From the crowding together of the teeth the trouble seemed to be situated in the interior of the bone, and the absence of the second molar strongly pointed in the direction of a dentigerous cyst, or some other form of odontome; against this was the fact that the swelling extended far up the ramus of the jaw. The other suggestion was that of sarcoma; but one was inclined to think that the long history went in opposition to this: however, the exploratory incision soon settled the matter.

The wound united by primary union, leaving a linear scar scarcely noticeable, and she was discharged on April 3rd.

The next case is a case of periosteal sarcoma of the head of fibula. This was a very interesting case on account of the difficulty of diagnosis. It was refused by at least one house-surgeon, who thought that it was an abscess. I took the patient in, as it seemed to me from the first time I saw him, that it seemed very much like growth.

Patient was a young man, æt. 20, a labourer, and was admitted on the 30th of May of this year. Two months before admission patient noticed a pain in the outer side of right leg, and on looking at the part he noticed a swelling there. The pain was constant and shooting in character with exacerbations, which chiefly occurred at night. Since then the swelling has gradually increased in size. Patient never felt any sensation of anything breaking, and has been walking on the leg up to the date of admission.

On admission.—There was a swelling on the outer side of the upper part of right leg. It measured six by five inches; it was smooth and sessile, and the edges were hard and raised from the surrounding parts. There is very marked fluctuation over the middle of the tumour where the skin was red and adherent and the superficial vessels dilated. The centre of the swelling is on a level with the tubercle of the tibia, and it extends from the middle of the patella downwards for five inches. Below this is a separate lump which gives the same feeling to the fingers as an enlarged gland would. This lump is movable on deeper structures, and the skin can be pinched up over it, and it is about the size of a walnut. The circumference of the right leg at the level of the tubercle of the tibia is 13¼ inches, that of the left being 11⅝ inches. On manipulation, a slight crepitant feeling was felt in the tumour. There were hard, shotty glands to be felt all over the body except in the popliteal spaces, where no glands could be felt. The vertical glands in the right groin were large and soft.

As the temperature went up to 101·2°, on the evening of 31st May, it was decided to open the swelling, and if there was any pus in it, which I very much doubted, to evacuate it. On examining the patient under the anæsthetic, I found that the fibula was fractured transversely about 1½ inch below its head. An incision of 1½ inch was made over the most prominent part of the swelling, and a mixture of blood and masses of softened growth evacuated. The head of the fibula could be felt quite bare. As the consent of the parents for a bigger operation had not been obtained, the wound was dressed and patient taken back to bed.

I asked Mr. Golding-Bird to see the case with me, and he agreed with me that it was a case in which one should try to remove the growth without removing the limb.

On June 7th, permission having been obtained to amputate if necessary, patient was taken to the theatre, and A.C.E. administered.

There Mr. Davies-Colley saw the patient and thought that it would be impossible to remove the growth without having to remove the limb, as the remaining part would be worse than worthless, owing to the drop-foot, caused by the cutting of the external popliteal nerve.

Then I decided to cut down and see whether the external popliteal nerve was involved in the growth, so that I would be able to dissect it out of the growth and leave it there. When I exposed the nerve, however, I found that not only was the nerve involved in the growth, but that a considerable portion of it was infiltrated by the growth.

I then decided to amputate the leg at the knee-joint, but as the joint did not seem healthy I decided to amputate higher up in the lower third of the thigh, which I did by anterior and posterior flaps, twisting the arteries instead of ligaturing them, as they are thus safer against secondary hæmorrhage.

On examination, the swelling proved to be a periosteal growth, apparently originating in the periosteum of the head of the fibula, and infiltrating all the surrounding parts.

There was a little hæmorrhage from the stump after amputation, but none of any importance, and in about a fortnight patient's temperature went up to 101°, but no cause could be discovered, and patient is now doing well.

The third case is that of sarcoma of the testicle. This was a private patient and is a medical man. Four months ago he noticed some thickening along the inner side of his left testicle. He had had a varicocele, and had had syphilis 12 years ago. This swelling had been rapidly increasing in size the last six weeks, until it has reached its present size, the circumference of scrotum being 13 inches. There was no infiltration of the cord, the swelling was perfectly smooth and uniform, and very elastic, and it was opaque. I thought that it was a malignant growth.

The view which he himself had previously taken of it was that it was syphilitic; but now he was rather inclined to think that it was carcinoma, as there was some history of carcinoma in his family. As the spermatic cord was not implicated I thought it was sarcoma. I told him to take big doses of Potassium Iodide for some three weeks, and if it did not improve to return to me, and I would remove it. As I thought, there was no improvement at the end of the time: just a little fluid could now be made out in the tunica vaginalis.

In examining these cases of enlarged testes you should have some definite plan, such as the ollowing:—First examine the cord to see if it is thickened, or whether you can feel anything else besides the cord. In this case the cord was perfectly free.

Next look for translucency, for you may have a translucent tumour very hard owing to the sac being very tense. In this case it was perfectly opaque.

Now palpate the tumour. This tumour was quite uniform; but growths, as a rule, have nodules on their surface. Another question was whether it was a hæmatocele. The history disproved this.

It is very difficult to diagnose between sarcoma and carcinoma of the testis in adults. The chief point here is that the cord is not affected, which is almost always the case in carcinoma. Then I decided to perform castration, which I did, cutting the cord as high as possible, in order to lessen the chance of its recurring there, and removing the tumour intact.

On cutting through the tunica vaginalis a small amount of fluid escaped, and exposed a soft red mass of growth; this, on microscopic examination was found to be a mixed-celled sarcoma.

I hope, the cord not being involved, that the growth will not recur in this case It may, however, recur in the stump of the cord or in the vessels.

In the first case the prognosis is good, it will in all probability never recur, but in the second case it is almost certain to recur.

With the Reserve Fleet: Naval Manœuvres, 1895.

Towards the end of July, I received the following: "On Her Majesty's Service":—"You are appointed to H.M.S. 'Wobbler' for the manœuvres."

Well and good; off I went, and duly reported myself on board the above-mentioned gun-boat, hoping for fine weather, but hoping, alas, in vain. The very first day was enough to reduce the "Doctor" to a state which made it profitable for passers-by to look into his cabin with elaborate sympathy and enquire as to whether "a little fat pork" would be to his liking for dinner.

There is much to be said against a small ship as opposed to a large one in the way of comfort, but *vice versâ*, there are many advantages: thus, as a set-off against the oiliness, stuffiness, excessive rolling and wet decks (necessitating closed scuttles and sky-lights

nearly all the time), there is a lack of stiffness and formality, and the knowledge that one can get a boat for shore whenever one wants one in port, which in fine weather makes life in a gun-boat almost like a yachting cruise.

A remarkable point in the "Wobbler" was the steepness of the ladders; that down to the steerage-flat, cabins and ward-room was especially steep, and was faced by a rifle-rack; thus it frequently happened that a passage "down-below" ended in a crash and bad language, then there would be an ominous silence, after which everyone within hearing would commence to whistle, "Jimmy on the shute, boys," as a sort of consolation for the sufferer. (Many were the bits I chipped out of those rifles).

We sailed from Portsmouth to Torbay, where we stopped a few days, waiting for all the fleet to assemble and coal. While we were in the bay we had lovely weather, and, consequently, everyone who was able went ashore—and had a very good time. Apropos of which, comes to my mind a yarn spun by a very corpulent lieutenant belonging to another ship, who presumably had been severely smitten by the attractions of some Torquay damsel. He was discovered, some days after we left, to be writing a poem, which was entitled "Memory," and which began as follows:—

"Memory bitter, memory sweet
Of long ago, time's wing is fleet.
What! can the past be ne'er again?
Memory's pleasure, memory's pain."

Poor chap, he had a bad time; if he came into the ward-room, or smoking-room, or wherever two or three were gathered together, the following conversation would commence. Jones would look up innocently, and say, "What is memory?" to which Smith would reply solemnly, "Memory is bitter"; this fact Robinson would debate, with the postulate that "Memory was sweet"; a lengthy argument would then ensue, until it was agreed that "Memory was stout and bitter," or something equally foolish. Whereupon—if he had not disappeared before—the love-sick and exasperated officer would rush out of the room, followed by roars of laughter from his torturers.

From Torbay to Bantry Bay we had it fine and smooth, and the whole fleet sailing together, formed a very fine sight, but from there until we got to the north of Ireland—Lough Swilly—we had very unpleasant times, rough and cold and wet.

There were two individuals in the ship who disliked rough weather quite as much as I did, one was the assistant engineer, and the other was the captain's dog, a big, black retriever, called "Nigger"; they both suffered severely from *mal-de-mer*.

In spite of rolling so much, the "Wobbler" class are very good sea boats—we rolled 40° to port and 35° to starboard one day, but I think we could have gone several degrees further both ways, without anyone doubting the stability of the ship.

The west coast of Ireland, as I suppose everyone knows, is extremely wild and rocky; it looked especially forbidding in the dirty weather we had. I particularly remember two very desolate islands, called the "Skelligs," between which two ships-of-war ran on the rocks some years ago; they were sufficiently imposing—bare, steep and rocky, washed at foot by a grey, turbulent sea, and threatened overhead by heavy storm-clouds, while behind them could be seen the mainland, looming out from the mists as inhospitable as her daughters, the islands; it did not require a very imaginative mind to people the coast with wreckers, the shore with broken spars and corpses, and the air with the cries of the drowning.

If my opinion were asked, I should say that Lough Swilly was a very dreary place; everyone, however, may not agree with me, and I am, therefore, open to correction. There are golf links at Buncrana, and that was quite enough to make a lot of people happy—witness the daily entry in his diary of a golf-enthusiast friend of mine:—

Saturday.—Went ashore; played golf; came back.
Sunday.— —— ——
Monday.—Went ashore; golf; back.
Tuesday.—Shore; golf; back.
Wednesday.—Shore; golf; back.

And so forth. He was supremely happy, and the perusal of his diary seemed to afford him endless pleasure; it reminded me of Mark Twain's daily entry into his journal, when a boy—"Got up; washed; went to bed."

There is a certain amount of mystery about the entry for Sunday, but I am very much afraid that also should read, "shore; golf; back;" perhaps religious scruples made M. withold his pen here.

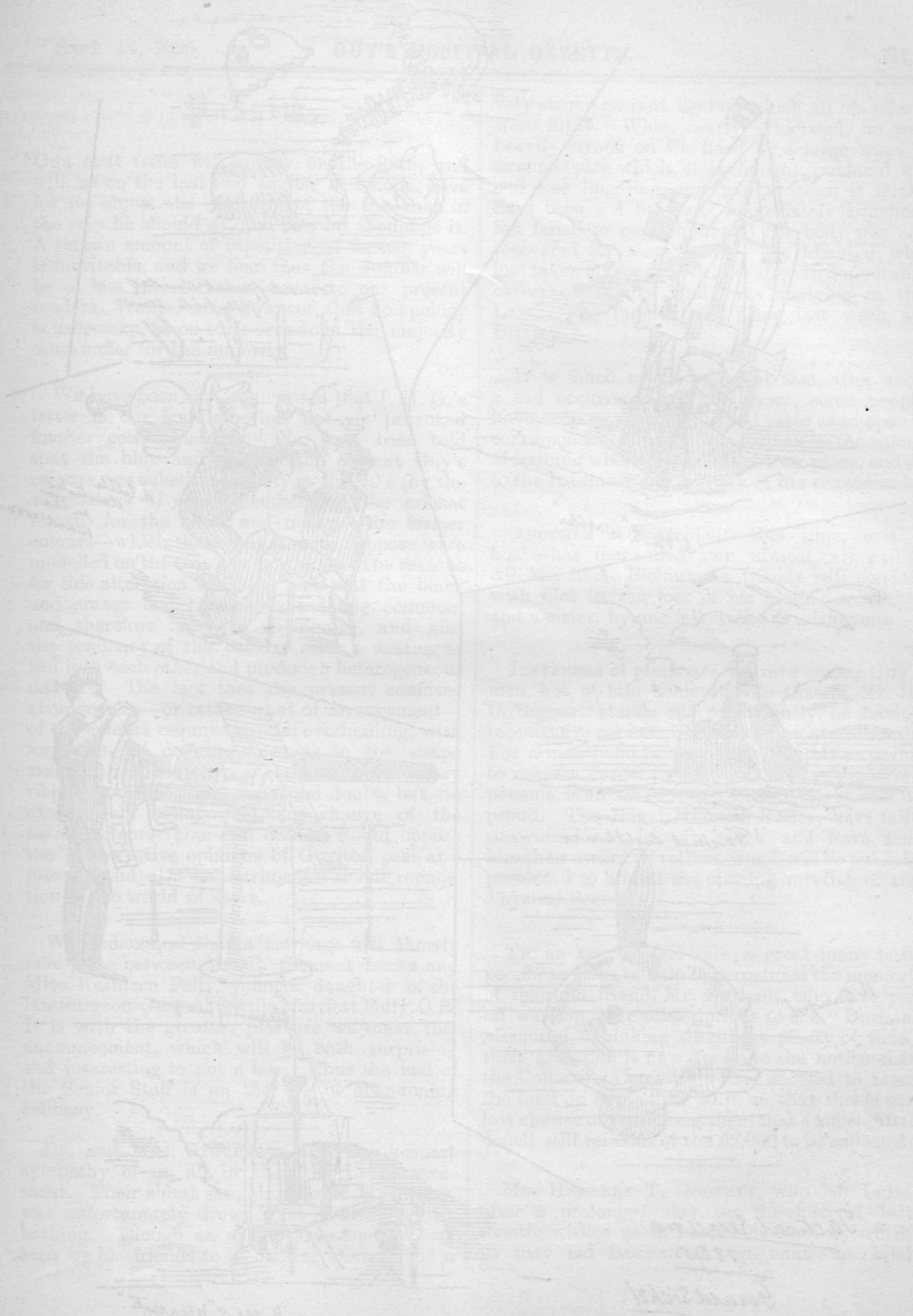
Talking of religious scruples reminds me of "Church" on board on Sundays.

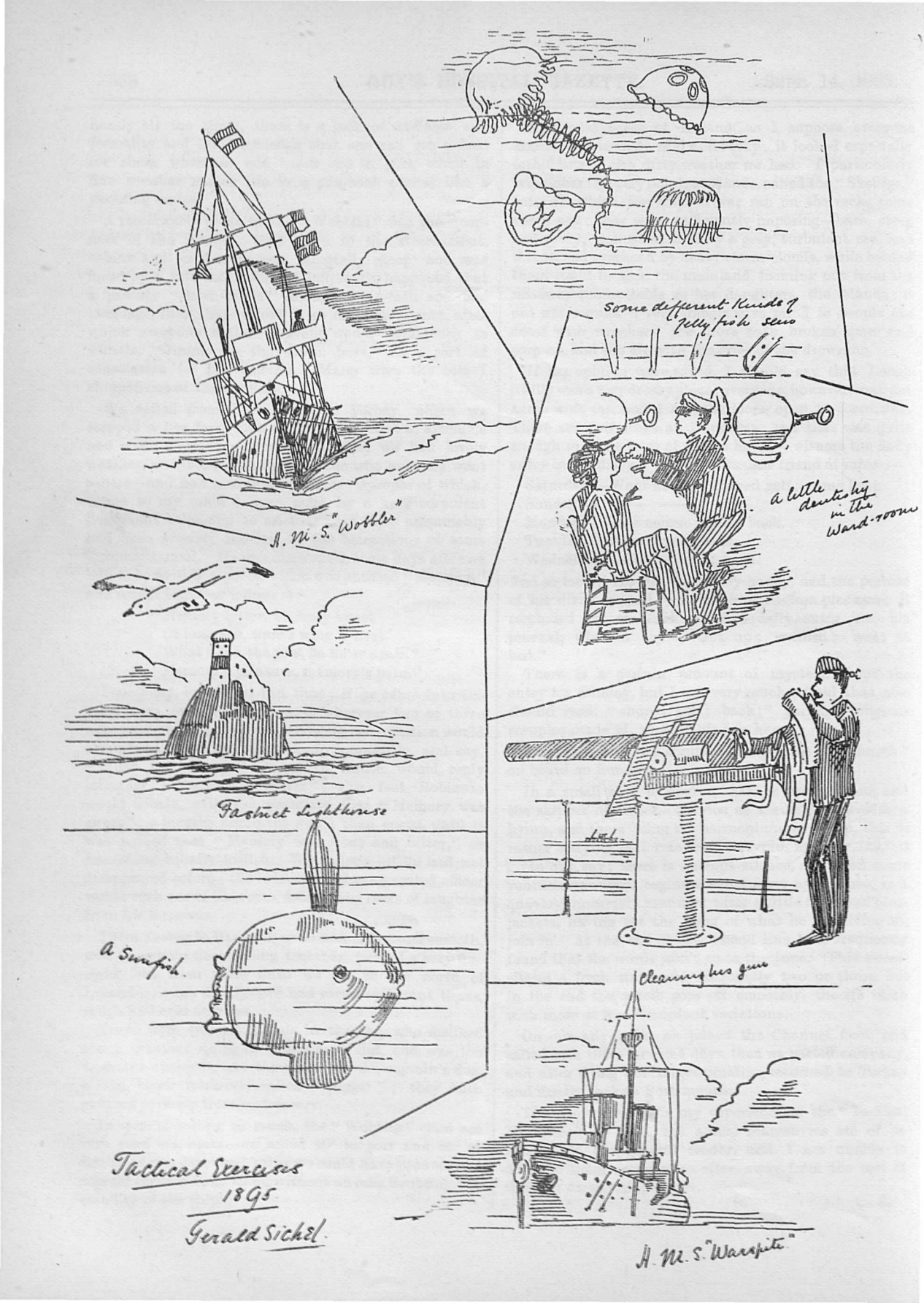
In a small ship, of course, there is no chaplain, and the skipper officiates. Service as a rule begins with a hymn, and there being no harmonium or organ, this is rather a trying performance. "Hymn, number 159," is given out, say; there is nervous silence, and then some venturesome spirit begins a well-known hymn-tune, in a quavery, uncertain manner; after a little the other blue-jackets, having got the hang of what he is driving at, join in. At the end of the second line it is frequently found that the words won't go to the tune. This necessitates a fresh start, and frequently two or three, but in the end the whole goes off smoothly, though often with more or less discordant variations.

On our way back, we joined the Channel fleet, and sailed with them for some days, then we parted company, and after doing our target-practice, returned to Torbay and finally back to Portsmouth.

The above shortly is my experience of the "Tactical Exercises" of 1895, the actual manœuvres are of no interest to the general reader, and I am unable to describe them as we were often away from the rest of the fleet on scouting duties.

G. S.





Tactical Exercises
1895

Gerald Sichel

Passim.

Our next issue will appear on the 28th, and will, as on the last two similar occasions, have for its object the direction of the freshman in the way he should go, and how he should go it. A certain amount of repetition of former years is inevitable, and we fear that the number will be of less interest than usual to our present readers. We feel sure, however, that no apology is necessary, as on such occasions the majority must suffer for the minority.

We have been rather surprised that J. H. G.'s letter in our last issue has not yet provoked further correspondence. We have been told that the blue and gold of the present Guy's colours was substituted early in the '70's (by the suggestions of some members of the cricket eleven) for the black and orange—the former colours—which there is reason to suppose were modelled on the Guy's coat of arms. The reasons for this alteration were the fact that the black and orange had become exceedingly common, and therefore hard to distinguish, and also the tendency of the colours after a wetting to run into each other and produce a heterogeneous mixture. The fact that the present confused arrangement—or rather want of arrangement—of the colours requires careful overhauling, with formation of definite rules as to the shape and width of the stripes, both for the ordinary ribbon and the Blue, is beyond doubt, but we cannot help feeling that any change of the actual colours (blue and orange) would oppose the conservative opinions of Guyites, past and present, and also be detrimental to our reputation in the world of sport.

We understand that a marriage will shortly take place between Mr. R. Clement Lucas and Miss Kathleen Pelly, younger daughter of the late Surgeon-General Saville Marriott Pelly, C.B. It is with the greatest pleasure we make this announcement, which will be both surprising and interesting to not a few. Thus the last of the Senior Staff is on the eve of abandoning celibacy.

Dr. and Mrs. Stevenson have the keenest sympathy of us all in their recent bereavement. Their eldest son, Mr. Harold Stevenson, was unfortunately drowned at Whitby whilst bathing. Though an expert swimmer, he was seen by his friends to be drifting seawards in a very strong current, against which all his efforts were futile. When nearly exhausted, he was heavily struck on the head by a large wave, a circumstance which, it is thought, rendered his end less lingering and painful than it might have been. A boat was immediately launched, but failed to reach him, and the body was not recovered for some hours. The deceased, who had taken a very good degree after an honourable career at Trinity Hall, was studying in the Law. The funeral took place last week at Brixton.

It is much to be regretted that, after such a sad occurrence as the above, some people have been so wanting in good taste as to open a correspondence in the *Standard* as to the safety of bathing where the accident took place, and as to the readiness and activity of the coastguards.

Another sad accident—this time from a boat—has demanded our utmost sympathy. All Mr. B. A. Richmond's friends will condole with him in the loss of his mother, a brother and a sister, by one fell stroke of misfortune.

Instances of pluck are not rare among Guy's men, but of late achievements that of Mr. H. C. Regnart stands out prominently, he having rescued five persons from drowning at Aldburgh. For a man (who is, we believe, unable to swim) to venture to row to, and pull out five drowning persons, is an act of which anyone might well be proud. The Royal Humane Society have fully recognized our friend's pluck and have sent him their award on vellum, which will be publicly presented to him at the opening meeting of the Physical Society.

There are, we feel sure, a great many busy people anxious to help to perpetuate the memory of their old friend, Mr. Durham, who have put off sending their subscriptions to the "Durham Memorial," thinking there was plenty of time; their attention is now drawn to the notice that the Collecting Committee have decided to close the fund on September 30th, so that this is our last chance of reminding them that a substantial deficit still remains of the £2,000 to be collected.

Mr. Herbert T. Godfrey, who left Luke, after a prolonged stay, on the fifth of last month, wishes us to be the medium by which he may bid farewell to his numerous kind

friends in the Hospital. Everyone who chanced to know him will wish him renewed strength and health.

ANOTHER faithful servant has left us—not this time by joining the majority, but by gaining a more lucrative post—for last week Pepper, who for the past three years has been one of the College Porters, resigned his post and went to University College. Several of the Residents, bearing in mind his industry and good-nature, have started a small subscription for a farewell gift, and it would give us the greatest pleasure to be the means of bringing this to the notice of any old Guyites who once resided in the College. Sums of money, not to exceed five shillings, should be forwarded to Mr. C. E. Carpmael.

WE have received the educational number of the *Lancet*, and find it as full of information as of yore. We must own that the article which chiefly occupied our attention was that headed "Hospital Athletics," and the same may probably be said of a large number of fathers and guardians who are now thinking of sending their sons up to one of the London Medical Schools. In the article under notice the name of Guy's appears prominently so often that one scarcely seemed to see another hospital's name; we only hope that the illusion (if we may so term it) may be further intensified by the time next September arrives.

WE are specially requested to call the attention of all our readers to the House Dinner which will take place on Tuesday, October 1st, at 7 p.m. Application for tickets (price three shillings and sixpence) should be made at once to the Honorary Secretary, Guy's Hospital Students' Club, as there is only a very limited number for disposal.

Appointments.

CAMPBELL, HENRY JOHNSTONE, M.D., M.R.C.P. Lond., M.R.C.S., has been appointed Honorary Physician to the Bradford Infirmary, *vice* W. G. Grabham, M.D. Lond., resigned.

GROVE, W. R., M.D. St. And., M.R.C.S., has been appointed Medical Officer for the Workhouse of the St. Ives Union.

TAYLOR, J. W., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer of Health for the Methley Urban Sanitary District, *vice* Wigan.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY	12.	To and fro bruits in pulmonary area. ? Aortic. ? Pulmonary.
	13.	Aortic aneurysm. Aortic stenosis and regurgitation.
	23.	Mitral stenosis.
	25.	Mitral stenosis and regurgitation.
	26.	Ulcerative endocarditis.
PHILIP	5.	Aortic stenosis (pulse 32).
	8.	Mitral and pulmonary regurgitation.
	10.	Ulcerative endocarditis.
	23.	Mitral regurgitation.
	35.	Abdominal aneurysm.
STEPHEN	14.	Mitral regurgitation. Enlarged liver.
	19.	Aortic disease.
	20.	? Aortic aneurysm.
	28.	Mitral regurgitation.

Nervous System.

MARY	2.	Cerebral tumour. Optic atrophy. Trephining four times.
	15.	Hysterical aphonia.
	16.	Cerebral tumour. Optic neuritis.
	17.	Paraplegia following influenza.
PHILIP	24.	Writers' cramp.
	31.	Idiopathic muscular atrophy.
	39.	Right hemiplegia.
STEPHEN	9.	? Syringomyelia.
	21.	Right hemiplegia. Cerebral syphilis.

Alimentary System and Abdomen.

MARY	3, 33.	Gastric ulcer.
	20.	Jaundice. Carcinoma of liver.
	22.	Carcinoma of liver.
	31.	Tubercular peritonitis.
PHILIP	9.	Enlarged liver and spleen.
	13.	Jaundice. Carcinoma of pancreas.
	18.	Abdominal tumour. ? Carcinoma of stomach. ? Carcinoma of colon.
	28.	Plumbism.
	33.	Carcinoma of rectum.
STEPHEN	4.	Jaundice. Enlarged liver. ? Distended gall-bladder.
	7, 25.	? Cirrhosis of liver.
	13.	Plumbism.

Typhoid Fever.

MARY	5, 7, 17, 21, 28.
PHILIP	4, 19, 25, 38.
STEPHEN	5, 15, 17, 22, 29.

Genito-Urinary System.

MARY	6.	Tuberculous kidney. Nephrectomy.
PHILIP	12.	Diabetes mellitus.
	36.	Hæmaturia. Tubal nephritis.
STEPHEN	3.	Hæmaturia. ? Cause.
	30, 31.	Acute nephritis.

Respiratory System.

MARY	35.	Empyema.
	36.	Pleuritic effusion.
PHILIP	2.	Pleuritic effusion. Phthisis.
	22.	Hæmoptysis. Phthisis.
	32.	Fibroid lung. Bronchitis.
	40.	Bronchitis and emphysema.
STEPHEN	10.	Empyema following pneumonia.
	23.	Tuberculous laryngitis. Phthisis. Mitral regurgitation.
	33.	Pleuritic effusion.

Phthisis.

MARY	10.	
PHILIP	2, 16, 22, 31.	
STEPHEN	11, 24, 35.	

Miscellaneous.

MARY	1.	Raynaud's disease.
	8.	Eczema.
	19.	Rheumatism.
PHILIP	20.	Multiple sarcomata.
	29.	Lymphosarcoma.

THREE CASES OF JAUNDICE.

UNDER DR. GOODHART.

A. CARCINOMA OF LIVER. ? PRIMARY SEAT OF THE CARCINOMA.

MARY 20. Female, æt. 65. Admitted August 19th, 1895, for jaundice. No family history of malignant disease. She was a housekeeper; in 1850 she was married, and in 1865 was married again. No children. In 1870 she had an attack of rheumatic fever, and since then has never been laid up until her present illness commenced. Late in June this year she first noticed that her appetite was poor and that she was getting weak and unable to do her work. Six weeks ago she first noticed jaundice; her urine was dark, her motions very light in colour, her skin itched, and she suffered from constipation.

On admission.—Skin a deep yellow colour, conjunctivæ a bright yellow; tongue furred. The edge of the liver could be felt about one inch below the level of the umbilicus in the right nipple line; it was sharp and well defined. The surface was hard but quite smooth, no nodules being made out; it was slightly tender when palpated. The dulness extended from the fifth right space in the nipple line to one inch below the level of the umbilicus. No ascites. No other abdominal tumour detected. Urine 1012, acid, deep mahogany colour, due to the presence of a large quantity of bile pigment. Respiratory and circulatory systems normal.

Sept. 4th. Patient still deeply jaundiced. Skin of a greenish-yellow tinge; she is very much emaciated. She complains of a constant feeling of nausea, but she does not actually vomit. Condition of liver as above.

B. CARCINOMA OF PANCREAS. DISTENDED AND SUPPURATING GALL-BLADDER.

PHILIP 13. Male, æt. 55. First admitted April 3rd, 1895, for jaundice, weakness, and giddiness. He was a wheelwright by trade. For the last 20 years has taken no stimulants. No family history of malignant disease. Twelve years ago was ruptured, and since then from time to time has had a fluid accumulation in the right side of his scrotum, for which he has been tapped. His present illness started with a rigor on March 12th, followed by two or three more on the following evening. He was treated for influenza. After being under treatment for 10 days his doctor noticed that he had jaundice.

On admission.—He appeared to be thin and wasted; his normal weight was twelve stone. Skin a deep yellow colour, also the conjunctivæ. Tongue slightly furred. No abdominal distension; left flank tender; liver felt $2\frac{1}{2}$ inches below the costal margin in the right nipple line, dulness commences above, at the sixth rib; length from sixth rib to edge of liver in the nipple line, seven inches. Bowels constipated. Urine 1020, dark brownish colour from presence of bile pigment.

April 5th. Pulse 49.

17th. Pulse better; jaundice not quite so intense. Got up in the evening.

24th. Went to a convalescent home, and expressed himself as feeling better.

June 11th. Re-admitted. He feels worse, and has become weaker and thinner, and is more deeply jaundiced. Liver has not increased in size.

July 5th. Dr. Goodhart felt the patient's gall-bladder.

9th. Was very restless, and sweated a good deal. Temperature 105°.

10th. More rigors and sweating. Temperature 103·6°.

15th. Seen by Mr. Lane, who advised an exploratory operation.

18th. Operation by Mr. Lane. Gall-bladder found distended, and eight ounces of thick purulent fluid was withdrawn. A hard growth was also felt in the head of the pancreas, and a small secondary growth was seen on the front of the liver. The gall-bladder was drained by means of a tube, which was left in.

September 10th. Since the operation there has been no rise of temperature. There is still some discharge from the operation wound. He has become much more emaciated. His skin is of an olive-green tint. He says he feels better.

UNDER DR. TAYLOR.

C. ENLARGED LIVER. DISTENDED GALL-BLADDER. ? PRIMARY CARCINOMA OF THE GALL-BLADDER.

STEPHEN 4. Male, æt. 55. Admitted September 2nd, for jaundice. He is a carpenter. There is no family

history of malignant disease. He has always been temperate, and has enjoyed good health. He first felt unwell four months ago, when he lost his appetite, and he felt disinclined for work or exertion; he had severe itching of the skin; his urine was dark coloured, and his fæces very light in colour. Jaundice was first noticed a week after he first felt ill. During the first two months of his illness he lost 14 pounds in weight; during the last two months he has not wasted. He has had no pain lately, but two months before his skin became yellow he had severe pain in the right side of his abdomen, for which he took some brandy, which relieved him.

On admission.—Temperature 98·4°; respiration 18; pulse 72. Skin a deep yellow colour and covered with numerous scratch marks. Conjunctivæ yellow. Tongue furred. Bowels regular; motions soft and light in colour. The abdomen is not distended. Just below and to the right of the umbilicus is seen a slightly rounded prominence, which moves freely downwards beneath the abdominal parietes when the patient breathes. The edge of the liver can be felt on a level with the umbilicus, and just to the right of the umbilicus, and projecting downwards, is a large rounded mass, a little larger than an egg, which feels somewhat softer than the liver. The central portion of this mass is raised and more prominent, and feels like a nodule on its surface. This mass moves with the liver. In the nipple line the liver dulness extends from the sixth rib to two inches below the costal margin. The surface of the liver feels perfectly smooth. Circulatory and respiratory systems normal. Urine 1020; dark greenish tint, from presence of bile pigment.

September 9th. No change since admission.

In Case A.—A diagnosis of carcinoma of the liver was made on account of the patient's age, the intensity of the jaundice, the emaciation and the enlargement of the liver. The primary seat of the carcinoma has not been determined, as there are no definite signs or symptoms of disease of the stomach, pancreas, gall-bladder, rectum, uterus, or of any organ in which primary carcinoma usually occurs.

In Case B.—The diagnosis, when the patient was first admitted, was ? catarrhal jaundice. The subsequent operation, however, cleared up all doubts as to its nature, for the rigors were fully explained by the distension and suppuration of the gall-bladder and the wasting, by the presence of a primary carcinomatous growth in the head of the pancreas; the enlargement of the liver by secondary carcinoma of that organ.

In Case C.—The tumour, which projects from the liver, is in the position of the gall-bladder, and it has the physical character of a distended gall-bladder. There has been no rise of temperature, so that suppuration is unlikely and, further, there is very little tenderness when this tumour is palpated. There is a history of one attack of pain before the present illness commenced, which might possibly be explained by the presence of a gall-stone, which, if impacted in the common duct, would account for his present condition. Taking, however, into consideration his age, the wasting, the character of the jaundice, the enlargement of the liver and the distended gall-bladder, carcinoma of the neck of the gall-bladder with secondary carcinoma of the liver seems to best explain his present condition.

In the Surgical Wards.

Cases under Mr. Howse.

Accident	2.	Fracture of tibia. Pneumonia.
	9.	Fractured pelvis. Laceration of scrotum.
	13.	Dorsal dislocation of hip.
	21.	Run over. Hæmaturia.
	28.	Compound fracture of tibia.
	29.	Scalp wound.
	32.	Old compound comminuted fracture of forearm, with necrosis of fragments.
Charity	9.	Scirrhus of breast.
	10.	"Pulpy" elbow.
	11.	Punctured wounds of back. Subcutaneous emphysema.
	13.	Fracture of femur.
	14.	Fracture of pelvis.
Naaman	1.	Right inguinal hernia. Radical cure. ? Retained left testis.
	2.	Acute suppurative bursitis (knee).
	3.	Double synovitis of knee. ? Rheumatic. ? Syphilitic.
	10.	Ulceration of groin. Condylomata. Ulceration of rectum.
	13.	Carcinoma recti. Excision by removal of coccyx, etc.
	16.	Syphilitic periostitis.
	17.	Severe varicose veins. Thrombosis. Excision.

Cases under Mr. Davies-Colley.

Cornelius	1.	Concussion with ? contusion, followed by "fits."
	3.	? Growth of upper end of femur with spontaneous fracture.
	5.	Kick from horse in loin. Concussion.
	7.	Secondary hæmorrhage from dog-bite.
	9.	Concussion. Fracture of nasal bones, &c.
	12.	Fractured pelvis. Wiring. Wire removed after eight weeks. Firm union.
	14.	Sloughing buttock. Traumatic.
	16.	Injury to neck from standing on head. Deep suppuration.
	17.	Concussion. Scalp wound.
	18.	Intracapsular fracture of femur.
	20.	Compound fracture of tibia and fibula.
Lydia	2.	Ruptured eyeball. Enucleation. Congenital syphilis.
	3.	? Loose internal semilunar cartilage. Exploration.
	4.	"Housemaid's knee." Excision.
	6.	? Sarcoma of left breast. Removal.
	7.	Morbus coxæ. Dorsal dislocation.

LYDIA	9.	(Mother). Mammy abscess. (Child). Webbed fingers symmetrical, born with incisor cut.
	18.	Ovarian cyst.
	19.	Run over. Amputation through middle of leg.
	20.	Mastoid abscess with thrombosis of lateral sinus. Antrectomy. Ligature of internal jugular.
	21.	Genu valgum.
	22.	Cut ulnar artery. Torsion.
	23.	Osteitis of femur. Evacuation of pus.
	OCT.	Double inguinal hernia.
LUKE	1.	Fibrous polypus of naso-pharynx.
	2.	Acute necrosis of femur.
	5.	Goître adenomatus. Excision.
	8.	Salivary fistula. Removal of submaxillary gland.
	9.	Old tracheotomy for laryngeal obstruction. One vocal cord removed three years ago. Voice good. Closure of wound contemplated.
	18.	Malignant stricture of œsophagus. Gastrostomy contemplated.

CASES UNDER MR. LUCAS.

ACCIDENT	18.	Fracture of spine.
	31.	Fractured patella; wired.
CHARITY	4.	Cystic goître. Ablation.
	21.	Calculous cystitis. Lithotrity.
JOB	3.	Old fractured rib. Abscess of chest wall. Dementia.
	4.	Tuberculous glands of neck. Excision.
	8.	Old pulpy disease of knee. Excision.
	20.	Recurrent appendicitis. Removal of appendix.
	23.	Hydronephrosis. Nephrotomy.
	24.	Retained testes. Removal.
	25.	? Sarcoma of finger. Amputation.

CASES UNDER MR. GOLDING-BIRD.

ACCIDENT	10.	Fracture; dislocation of spine.
MARTHA	1.	Iliac abscess. ? Origin.
	2.	Adeno-sarcoma mammæ. Excision.
	6.	Umbilical hernia. Radical cure.
	9.	Lateral curvature.
	18.	Recurrent sebaceous tumours in thigh.
	21.	Sarcoma of head of tibia.
LAZARUS	7.	Mucous and malignant polypi of nose.
	8.	Epithelioma of tongue. Excision.
	17.	Suppurating nævus. Excision.
	18.	Hydrocele of funicular process. Closure of canal.
	20.	Inguinal hernia. Radical cure.

CASES UNDER MR. JACOBSON.

NAAMAN	5.	Epilepsy. ? Jacksonian. Trephining over scar.
	11.	Hydrocele. Right testis retained in canal. Testis planted in scrotum. Closure of canal.
NAAMAN	21.	Inguinal hernia. Radical cure.
	22.	Old suprapubic cystotomy.
CHARITY	15.	Double tuberculous disease of canal of Nuck. Removal of both. Closure of canals.
	19.	Stokes-Gritti for old ulcer.
	20.	Cystic change of breast. Excision.
DORCAS	1.	Genu valgum. Wedges removed from each femur. Osteotomy of tibiæ.
	2.	Stokes-Gritti for accident. ? Necrosis.
PATIENCE	1.	Chronic ulcer of leg; to be grafted.
SAMARITAN	12.	Erysipelas of scalp after hæmatoma. ? Hæmophilia.

CASES UNDER MR. SYMONDS.

MARTHA	15.	Nephrectomy for old renal disease.
JOB	11.	Malignant stricture of œsophagus. Tubage.
LUKE	16.	Inguinal hernia. Radical cure.
	17.	Spinal caries. Paraplegia (Sayer's jacket).
SAMARITAN	7.	Multiple periostitis, ? from influenza. Erysipelas.

CASES UNDER MR. LANE.

JOB	12.	Loose semi-lunar cartilage. Removal.
	14.	Growth of sigmoid. Colotomy.
	15.	Trigeminal neuralgia. Neurectomy of infra-orbital and auriculo-temporal.
CHARITY	21.	Carcinoma mammæ (en cuirasse). Æt. 29. Four months' history. Removal and disarticulation at shoulder.
DORCAS	4.	Ovarian cyst. Cœliotomy.
	5.	Ununited fracture of olecranon. Screwed.
PATIENCE	4.	Cellulitis about ankle.
	14.	Necrosis of olecranon.

CASES UNDER MR. DUNN.

MARTHA	5.	Genu valgum, double osteotomy of femur ten years ago.
	22.	Temporo-sphenoidal abscess. Evacuation.
LAZARUS	2.	Ununited fracture of tibia. Wiring.
SAMARITAN	8.	Periosteal abscess of lower jaw.
	9.	Caries of olecranon; scraped and packed with sulphur.

A Case of Spontaneous Expulsion.

THE Extern was called to this case, a German, aged 25—a primipara—on August 26th, at 2 p.m. On his arrival, a history was given to him of sharp pains every ten minutes since 4 a.m. of the same date up to 7 a.m. when they became less frequent. At 1 p.m. they again became frequent and remained so. The following facts were noted on arrival:—

2 p.m. *Os* size of a threepenny piece, rather hard except at the edge; membranes could not be felt. *Pains* frequent (every 10 minutes) and strong. *External*

palpation, a transverse position was thought probable, with the head in right iliac fossa. Pulse 96, good. Syr. Chloral Hyd. ʒiss. was administered, and an enema was given.

3 p.m. *Os* slightly dilated to about size of a shilling (or less). *Pains* as before. *Membranes* could be just felt. No diagnosis of the presentation could be made out, as no part of fœtus could be reached by the finger.

3.30 p.m. *Pains* not so frequent (every 20 minutes).

6 p.m. *Os* the size of a five-shilling piece or more. Membranes bulged out almost to vulva during a pain. A prominence was felt, but it was not certain whether it was elbow or knee; no foot or hand could be felt.

6.30 p.m. Membranes ruptured spontaneously. The right hand came down and was felt but not seen. The "Charities" were immediately sent for, and the diagnosis was then confirmed. Instruments and an anæsthetic were sent for. In the meanwhile patient was placed in Simm's position and encouraged to cry out during pain, and was, moreover, prevented from bearing down.

7 p.m. The pains now came on very rapidly, being almost continuous. On examination, the whole of right arm was outside the vulva, and the right shoulder, with the neck much flexed, was then seen presenting. As the greatest diameter of the fœtus was then obviously past the external os, patient was told to hold her breath and bear down during the next pain. The fœtus was expelled in that pain in the following attitude:—The head was flexed on to the chest, the left side of the face being in contact with the lower part of the sternum. The head being so low down was no doubt due to the elongation of the neck. The right arm was extended. The arm was expelled first. The head and chest together then followed, then breech, and finally legs. The placenta was expressed 15 minutes later.

Examination of fœtus.

Weight, 2¾ pounds.

Length, 17 inches.

Nails reached to end of fingers, but not to end of toes.

Testes.—The left testis was in scrotum, the right in genital canal about two inches from ring.

The fœtus was macerated and the skin was very easily separated. No lanugo could be seen, the back being practically the only part from which the skin had not separated.

Examination of pelvis of mother.

Distance between Iliac Crests, 10¼.

Distance between Iliac Spines, 9¼.

Ext. Conjugate 6½.

Diagonal Conjugate.—As the sacral prominence could not be felt by vaginal examination, the diagonal conjugate was not ascertained.

Comments.—The patient is very nervous and excitable; a German by birth; the husband being a West Indian. Patient accounts for the death of the child by her having run all the way to a fire, about a mile from the house, two days before the birth of the fœtus.

J. T. TULK-HART.

The Arthur Durham Memorial.

IT is proposed to raise a fund of £2,000 to endow in perpetuity two beds in memory of the late Mr. Arthur E. Durham. The following is the sixth list of subscriptions.

The Collecting Committee have to announce that it has been decided to finally close the fund on September 30th. All intending subscribers should therefore communicate with Mr. C. H. Wells on or before that date.

	£	s.	d.
Amount previously acknowledged ...	1,603	0	0
Samuelson, Right Hon. Sir B., Banbury ..	10	10	0
Williams, H., Esq.	5	5	0
Wells, C. H., Esq., Guy's Hospital	5	5	0
Faithful, Mrs. G., Gloucester Terrace ...	3	3	0
Greenwood, E. Climson, Esq., St. John's Wood	2	2	0
Burton, H. C., Esq., Blackheath	2	2	0
Munden, C., Esq., Ilminster	2	2	0
Jackson, T. S., Esq., Liss	2	2	0
Eve, The Misses, Notting Hill	2	2	0
Williams, R. E., Esq., M.B., Woolwich (2nd donation)	1	1	0
Armstrong, R. S., Esq., Chippenham Road, W.	1	1	0
Hugill, G. F., Esq., Balham	1	1	0
Davies, H. A., Esq., Newton Abbot	1	1	0
Lansdale, W., Esq., M.D., Trinity Square ...	1	1	0
Emms, A. Wilson, Esq., Belgrave, Leicester	1	1	0
Marshall, J., Esq., Grange Road, S.E. ...	1	1	0
Butcher, H. O. F., Esq., Ware	1	1	0
Bryant, J. H., Esq., M.D., Guy's Hospital ...	1	1	0
Smith, Austin H., Esq., M.B., Canterbury ...	1	1	0
Newton, Miss, The College	1	1	0
Gibson, W., Esq., Grantham	1	1	0
Soper, W., Esq., Clapham Road	1	1	0
Pinching, C. J. W., Esq., Gravesend... ...	1	1	0
Sichel, G., Esq., R.N.	0	10	6
Per H. Millson, Esq.—			
Brown, G., Esq., Talbot Court, E.C.... ...	1	1	0
Per C. E. Carpmael, Esq.—			
Aston-Key, M., Esq., M.B.	0	10	6
	£1,654	9	0

The subscription announced in our last issue as from "J. H. Gordon" should have read J. H. Godson, Esq.

Reynaud's Disease in Acute Mania.

THE occurrence of Reynaud's disease in Acute Mania is of considerable interest, throwing as it may some light on the pathology of this latter condition. I have not found any previous records of this association, although other angio-neuroses such as urticaria are not uncommon.

1. Arthur C., æt. 21, shop assistant, admitted December 29th, 1894. Family history bad. Paternal grandfather died insane, and mother was for some months in asylum. A week previous to admission patient got wet through, and on the following day had two convulsive seizures, followed by marked mental symptoms.

On admission, he was suffering from acute mania in its most typical form, extremely restless and violent with great mental exaltation. For three days he was confined to the padded room (temperature kept at 60° Fah. by hot pipes). On the 15th January, he complained of severe burning pain in his toes, and on examination they were discovered to be of a dusky grey colour, developing in 48 hours to bluish black, and presenting the appearance of having been dipped in ink, the distal phalanx of each toe being most affected, and the right foot more so than the left; at this period there was no clear line of demarcation. On the right heel was a patch of marble whiteness surrounded by a slightly congested area; this was apparently then anæsthetic, but it subsequently became gangrenous and painful. On the 18th, the second and third fingers on the left hand, and the third and fourth on the right, were noted to be similarly affected. Patient kept in bed and the affected parts enveloped in cotton wool.

The urine somewhat scanty and highly coloured, but at no time was hæmoglobinuria noted. Knee-jerks exaggerated, and no peripheral neuritis present. During the next week, small superficial gangrenous sloughs separated, giving a somewhat punched-out appearance, but there was no extension and the underlying surface was covered with healthy granulations. The nails were shed, but the matrix was not destroyed, and they were gradually replaced. The process of repair was slow, and three months had elapsed before the tissue was soundly healed, then leaving small puckered scars. In May the patient was mentally convalescent and allowed home on trial.

2. Lucy N., æt. 18, general servant; mother at present in an asylum. Nothing important in personal history. Admitted on the 23rd February, 1895, suffering from acute mania. She was exceedingly restless and troublesome, noisy and incoherent, and refused food from the first. On the 28th, the great toe on the left foot, and first and second toes on the right foot, were noticed to be of a blue-black colour and intensely painful. Small gangrenous patches also appeared on the helix of each ear and these rapidly sloughed. On the 1st March, the affected areas were found to have spread towards the dorsum of the foot. The patient passed her urine in the bed, so systematic examination was impossible; in the only instance it was collected and examined a negative result was obtained. The patient was fed three times daily by the stomach pump, and stimulant freely given. She, however, rapidly emaciated, and died on the 7th from the exhaustion of acute mania. A post-mortem examination was unfortunately not obtainable.

Both the above cases, it will be noted, occurred in the winter, but in each the patient had been some days in a room of uniform temperature without the possibility of exposure. The view that Raynaud's disease is an angio-neursois dependent on vaso-motor constriction of the smaller vessels supplying the part affected is generally believed. How far a vaso-motor storm theory can be applied to the pathology of acute mania is difficult to say.

The post-mortem appearances are neither definite nor constant. General anæmia, with excess of sub-arachnoid fluid or congestion of the meninges and brain substance, with consecutive degeneration of neuroglia and cells, occur in fatal cases presenting during life very similar symptoms.

But the desire to find a common pathological basis, for associated though apparently very different conditions, prompts one to consider two such consecutive cases as more than a coincidence.

F. H. E.

An Injury to the Heart.

One morning, a short time ago, while visiting a patient, I was asked to come at once to see a small girl a few doors off, as she had fallen on a needle which had entered the chest. I found on examination that the needle had been broken, but could be seen projecting under the skin in the fourth intercostal space, immediately to the right of the sternum, and rising and falling with the heart beats. The child was rather frightened and breathing quickly, but in no pain or distress. Thinking that if we moved her the needle might get pushed further in, I determined to try and extract it then and there. The skin was easily rendered insensible with a local anæsthetic, and an incision made over the end of the needle, which was now bobbing up and down like a float. An attempt was now made to grasp the end of the needle and extract it with dressing forceps, but owing to its continued movement it was found difficult to get a firm hold, and when this was obtained the difficulty in extraction suggested that the needle had really just pierced the cartilage. The slight delay had frightened the child, and as she was very pale and inclined to faint she was laid on a table, when her natural colour soon returned. However, just as the needle was removed (the portion extracted being about 1½ inch long) an extraordinary condition of collapse set in; her colour became dusky purple, very different from both her normal colour and the pallor of her previous faint. The jugulars became enormously distended and no pulse was perceptible at the wrist. The heart could be heard beating very slowly and the sounds were muffled, but there was no friction sound. The pupils were dilated and the conjunctiva barely sensitive. Injections of brandy and hot flannels to the præcordium gradually improved the condition, and in about half-an-hour the child was put into bed. The subsequent recovery was rapid, no pericardial or other symptoms developing.

It was at first thought that the shock was due to hæmorrhage into the pericardium, but the sudden onset, absence of friction sound, and speedy complete recovery rather negative this view, and it seems more probable that the symptoms were due to the direct injury to the auricle causing inhibition of its action. H. M. S.

Chorea Gravidarum.

THIS case is published by the kind consent of Dr. Rawlings, from notes by C. G. Burton.

Anna J., a single woman, æt. 20, was admitted into Swansea Hospital on June 24th. She was here four years ago suffering from chorea. She had rheumatic fever seven years ago.

Present illness began three weeks ago. Patient is five months pregnant. The movements are extremely violent, all four limbs, body, head and tongue being affected. Occasionally she lies quiet for a few minutes. The movements sometimes continue during sleep, but not so violently. Cardiac system normal.

Patient got steadily worse till July 9th, getting hardly any sleep and being frequently delirious. No treatment had any effect, except chloroform inhalations, which gave her a little sleep.

Premature labour was procured on July 10th. The fœtus presented by the shoulder and great difficulty was experienced in extracting it, decapitation having to be performed, the patient being under chloroform an hour and a half.

The patient's condition continued critical for the next week, the movements still being very violent. She developed a number of troublesome pustules on her hands, and her temperature twice rose to 105°.

On July 20th the temperature fell to normal, and she made a rapid recovery, being discharged on August 3rd, and is now quite well.

The case is worth reporting, from the fact that the improvement was delayed so long after labour had been procured.

S. F.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

C. T. B. M., MANCHESTER.—The tumour consists almost entirely of unstriped muscular fibre, and must be regarded as a myoma rather than a fibroma of the region from which it was removed.

E. R. F., COLD HARBOUR LANE.—A long bacillus, not unlike the bacillus subtilis, was the only micro-organism which made its appearance on the nutrient medium after twenty-four hours' incubation at 37° C. Nor could anything resembling the diphtheria bacilli be found in the membrane itself.

H. U. D., NEWTON ABBOT.—A few anthrax bacilli are present in the specimen of serum submitted to us.

E. A. S., TUNBRIDGE WELLS.—No tubercle bacilli could be detected in the specimen of urine.

E. A. S., TUNBRIDGE WELLS.—Tubercle bacilli are present in very small numbers in the sputum.

J. M. B., BURGESS HILL.—*Morning*—Reaction faintly acid, sp. gr. 1010; albumin, sugar and blood absent. Microscopic examination of the deposit shows the presence of amorphous phosphates and squamous epithelial cells, also a marked excess over normal of granular leucocytes. No tube casts could be found. *Night*—Reaction faintly acid, sp. gr. 1010; albumin, sugar and blood absent. Microscopical examination of the deposit shows the presence of crystals of stellar phosphates in fair numbers; also squamous epithelial cells and a few granular leucocytes. No tube casts were found.

G. T., HOLMWOOD.—After twenty-four hours' incubation on blood serum a very fine growth had taken place, which, microscopically, consisted of cocci arranged as streptococci and a short oval bacillus. No Klebs-Loëffler bacilli could be detected.

S. W., WOOLWICH.—The liver shows the characteristic features—both naked eye and microscopic—of the coarse variety of cirrhosis in an advanced stage. The specimen when received was much decomposed.

A. E. G., RICKMANSWORTH.—The growth is a vascular fibrous epulis, the mucous surface of which is ulcerated and covered with granulation tissue. There is no evidence of its being sarcomatous.

E. A. A., TUNBRIDGE WELLS.—The growth from the cheek is a squamous-celled epithelioma deeply infiltrating the deeper tissues.

PATHOLOGIST.

Birth.

GOODALL.—On July 31st, at Homerton, the wife of E. W. Goodall, M.D., of a son.

Marriage.

DALDY—HITCHCOCK.—On September 3rd, at St. George's Church, Bloomsbury, by the Rev. R. A. Hitchcock, assisted by the Rev. G. E. Hitchcock, brothers of the bride, and the Rev. A. B. Boyd-Carpenter, Arthur Mantell Daldy, M.D., son of O. G. Daldy, Esq., of Romford, to Mary Ellen, only daughter of the Rev. Canon Hitchcock.

Death.

STEVENSON.—On August 29th, at Whitby, from accidental drowning, Harold Thomas Stevenson, aged 27, elder son of Thomas Stevenson, M.D., F.R.C.P., of Sandhurst Lodge, Gresham Road, S.W.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Bon Jour!

Here's "How d'you do"
To each of you,
New comers, this October;
You're very wise
To come to Guy's,
And welcome, too, moreover.

Our good old "spit"
Is, every whit,
The finest in creation.
Mind you take care
To keep it there,
A credit to the nation!

And list to me,
An old gee-gee,
Who'd save you disappointment,
My whole advice
In two words lies,
"Be keen" through each appointment.

Look to your guns
When Footer comes,
Don't be content with "shop," sir,
If play you can,
Then play the man,
And don't give us the drop, sir.

When once again,
With might and main,
We strive to win the cup, sir,
Turn out in force,
Cheer till you're hoarse,
Or play till you're done up, sir.

Let cries of "Guy's"
Then rend the skies,
The whole air ring with praises!
Ye forwards all
Keep on the ball,
And run, ye backs, like blazes.

L. O.

The Introductory Lecture,

DELIVERED AT GUY'S HOSPITAL, ON OCTOBER 1ST, 1869,

BY C. HILTON FAGGE, M.D.,
Assistant Physician to the Hospital.

MR. TREASURER AND GENTLEMEN,—When I was invited to address you to-day, I did not consider that my comparative youth would be an excuse to me for shrinking from the burden imposed upon me. Around me, indeed, I see my seniors, to whom I would far more willingly have listened, and whose riper experience and fuller eloquence would have stamped deep into the minds of their hearers those lessons which we are all alike anxious to convey, and which I must do my feeble utmost to impress. But to this there is another side. So few years have elapsed since I was myself a pupil, that I must needs well remember what are a student's feelings and thoughts, and retain a ready sympathy with him in his difficulties, and in his struggles with the temptations that beset his path.

Nor, again, did I feel it my duty to decline on the score that I had no new things to tell you. An introductory lecture can seldom, I think, be very new. Even an oration, Harveian or Hunterian—repeated every year or two—is found to tax somewhat the inventive faculties of the orator. And how much more these lectures,—multiplied by being delivered annually at each of a dozen medical schools in London alone. However, I regard it as my present business not to startle you by novelty or paradox, but rather to tell to a section—and that the youngest section—of my audience a few truths, which, common-place truisms as some of them may seem, are, nevertheless, all-important to the student of medicine, and upon which it particularly behoves him to ponder when, as now, he is entering upon a new year of work, or is even standing on the threshold of an opening career. I shall, then, take leave to address myself to the students mainly, and, above all, to those who attend here for the first time.

But, even in these preliminary remarks, I am postponing that which ought to be the foremost topic of my discourse—the warm and hearty welcome which I am privileged to offer to you all, in the name of the authorities and the staff of Guy's Hospital. Believe me that this welcome is no mere formality. From to-day you are Guy's men; and we of Guy's pride ourselves on the strong *esprit de corps* which binds us all together.

Coming to this great overgrown city, perhaps for the first time, your home-ties suddenly severed, most of you are probably conscious of a void which you are anxious to fill. The next few days will be to each of you in the strictest sense *critical*. At the opening lecture on chemistry, when you first year's men will be almost alone, you will be an aggregation of unconnected units, a fortuitous concourse of atoms! A fortnight later you will be a very different body. Almost every one of you will have made some acquaintances; you may even have found *friends*. The character of these will, perhaps,—nay, probably,—affect your whole hospital careers, and even the course of your future lives. Many a man has been ruined by a thoughtless intimacy, contracted during the first few hours of his attendance at a medical school; many another, looking back on a student-friendship, will be ready to confess that the honours he may subsequently have achieved, and the skill and knowledge he may have acquired, are all in great part due to his friend's influence, whether by the contagion of sympathy or the stimulus of competition. I cannot too strongly urge you to be slow, and careful, in entering upon any associations during the early part of your studies.

Indeed, each year a certain general character may be easily recognised to belong to the students as a body;—a sort of *epidemic constitution*, which, although the resultant of individual characters, reacts incessantly on the individuals themselves, and thus exerts a very powerful influence for good or for evil. The most casual observer will one year see that the students are a very quiet, gentlemanly set of men; another year his verdict may be different. The fortuitous concourse quickly developes into an organised community.

Students, I think, are not sufficiently alive to the fact that from their general demeanour and conduct, their teachers, and the authorities of the Hospital, are constantly estimating both their intellectual powers and their moral dispositions. Dwell for a moment on the consideration that you yourselves cannot but form opinions as to the character and tendencies of all those with whom you are thrown into contact, even for the shortest possible period. Who among you hesitates to say whether an acquaintance, or even a person whom he knows only by sight, is likely to commit a particular action, or to carry out a particular line of conduct? Such judgments will necessarily be formed many times every day concerning each one of you, as you walk into the hospital, as you face the different lecturers in this theatre, as you work in the dissecting-room, or in the wards. I do not mean to say that the conclusions so arrived at are final; on the contrary, they are incessantly being added to and modified. All I say is, that each of you is subject to them. You cannot evade them; by no words of yours, or outward actions, can you of set purpose alter them. It is only by leading a blameless life—*sans peur et sans reproche*—that you can, if you will, render these judgments favourable to you, and gain our respect and regard.

But, besides these unwritten documents, an actual record is kept of the work you undertake and perform. The demonstrators report to the Medical Council the number of parts dissected by each student, and how he has discharged his duties. The attendances on lectures are noted down and registered. At the termination of each ward clerkship and dressership, returns are made to the Council of the manner in which the work of these various offices has been performed. It is by the light of

such reports that the Council are guided in selecting among the different candidates those most fit to be recommended to the Treasurer for the higher appointments. I would especially impress on you the importance of securing favourable reports from the first, by diligence and industry during the first year. Not only will you thus obtain a start in the race, and gain the junior offices at an early period; but you will acquire a cumulative energy that will avail you greatly hereafter. Many a man has failed in a competition for a dressership in his fourth or fifth year, from no cause except his having been idle in his first winter session.

The clinical appointments are, in some degree, peculiar to Guy's. So far as I am aware, there is no other medical school in which every part of the hospital practice, whether in-patient or out-patient, whether during session or in vacation time, whether in general medicine and surgery, or in the so-called specialties of eye-diseases, ear-diseases, skin-diseases, diseases of women, is in the same systematic way served by dressers or clerks, and made available for their instruction. And there are not many London hospitals where the facilities for this kind of work are so extensive. Even within the last five years great advances have been made in the regularity and completeness of our arrangements in this respect. Of the point to which they are now carried, you may form some idea from the fact that, including the house-physiciancy and house-surgeoncy, there are eighteen appointments,* having a total duration of at least fifty-three months. Supposing the student to hold all these offices in succession, beginning at the end of his first winter, and going on without a week's holiday, and without a single break, I find that he will not have completed them by the end of his fifth winter session.

I have purposely introduced this matter at the commencement of my address, because I wish you to understand that, beside distinction at the University of London, and hospital prizes, which can fall to the lot of few among you, your obtaining the higher clinical appointments is the great test of the success of your career here. They are all given, without payment, to the best men among the candidates, so far as can be determined. Some of you may, perhaps, think *now* that you would not greatly care to have a house-surgeoncy or house-physiciancy. If so, take my word for it, that hereafter you will be of a different opinion.

Nor do the offices I have named complete the career open to you. Our staff has for many years been recruited almost entirely from our school. Hardly one of those who will be your teachers, but at one period sat on those very benches as a student. A position like theirs is within the reach of each one of you, who can show that he possesses the needful qualifications. You may have heard it said that in the armies of the Great Napoleon every soldier carried a marshal's *bâton* in his knapsack, so open lay the path to fame and honour for every one deserving of them. I would fain hope that something not altogether different might, without falsity, be said of Guy's.

Let me now make a few observations as to the general course of study which ought to be adopted by those who would learn medicine. And you will not, I hope, misunderstand me, if I accuse some of you of being too much like schoolboys, and too little students in the right sense. I do not mean that you are too light-hearted, or even (which is possible) too fond of amusement, or lacking in due gravity and reserve; I am thinking of certain habits of study which belong to schools, and which, therefore, your past associations are likely to suggest to you, but which I would have you most carefully to guard against and avoid. The lessons learnt by the schoolboy seem often to be set for no other purpose than that he may learn to learn. He naturally acquires the notion that knowledge is intended not to be permanently stored in the memory, but simply to be piled up in the outer chambers of the brain, so as to be voided with facility and promptitude when the "lesson" has to be "repeated," or when the half-yearly examination affords a welcome occasion for disburdening the mind of its load.

A similar feeling is common in students, and betrays itself readily to those who will observe the symptoms of it. It alone will explain what has often been a puzzle to me, and is in fact an absurdity, that after an examination a man will express disappointment, and even disgust, because the examiners did not happen to ask a particular question. "He got up (perhaps) the internal ear, and all for nothing; he never had a single question in it." Instead of seeking knowledge for its own sake, he has been striving to learn just those points which he supposed were likely to be asked. He has forgotten that examinations are intended, not to elicit all that the student knows, but to take (as it were) *samples* of his information by questions scattered over its range.

Further, the traditions of his general education are apt to have left in the student's mind an undue belief in the value of *books* as instruments of learning. To the schoolboy reading and study are nearly convertible terms; his knowledge is derived almost wholly from books; their statements are not to be questioned by him, their authority is final. But to the medical student books are only one, and not the best, source of knowledge.

This matter is one of such vital importance to each of you—a forgetfulness of it may lead to such disastrous consequences—that I think I may well devote to its

* I append below the designations by which the holders of these various appointments are known, and the terms of their several offices.

	months.		months.
House-Physician	6	Dental-Surgeon's Dresser	2
*House-Surgeon	4	Aural-Surgeon's Dresser	2
Resident Obstetric Clerk	2	Medical Ward Clerk	3
†Surgeon's Dresser	6	Post-mortem Clerk	2
Clinical Clerk	3	Surgical Ward Clerk	3
Dresser in the Eye Wards	4	Extern Obstetric Attendant	1
Assistant-Physician's Clerk	3	Obstetric Out-patients'Clerk	3
Assistant-Surgeon's Dresser	3	Assistant-Surgeon's Clerk	3
†Dresser in the Surgery	3	Clerk in the Electrifying Room	

* Now six months.
† Now combined with alteration in duties.
Since this time other appointments have been made.—ED. G.H.G.

consideration a portion of the brief space of time allotted to me. We will ask, therefore—*What are the methods by which a knowledge of medicine and surgery may be obtained?*

Now, the first answer to this is that *observation* and *experience* are the foundation of all real knowledge of diagnosis, and are essential to all successful treatment. To know any one (except perhaps a few of the most obvious) of the diseases to which the human body is liable, and which are recognised by sight, or touch, or hearing, you must previously have seen, or handled, or listened to, other cases more or less similar. Whatever cases you first have to do with will be the raw material for your studies. If you do not get over the period of your probation by examining for yourselves the patients under *our* care in the wards, which are freely open to you for this purpose, you will hereafter have to pick up your experience—at whatever risk, and with whatever difficulty—from those who come to *you* for treatment, and to whom you will be responsible for it.

Now, there is enormous difficulty in acquiring by oneself, unaided, a knowledge of the more recondite branches of medicine. Every one of the senses has in turn to be educated and, indeed, sharpened. When a student begins to visit the wards, he will hear statements as to matters of fact which he will be utterly unable to verify. He will see the surgeon detect pus by means of fluctuation, and prove the accuracy of his judgment by thrusting a bistoury into the part, when he cannot, with all his efforts, feel anything abnormal. The obstetric physician may give him an opportunity of hearing the fœtal heart beat through the abdominal walls; but he will for a time be absolutely unable to detect the faintest sound, although he may listen ever so intently. Mr. Bader will tell him that the retina is anæmic or hyperæmic, and will place an ophthalmoscope in his hand; he will look and see nothing but a red patch: at the end of a week or two, if he persevere, he may be able to see, instead of the red patch, a white one with some blood-vessels running over it; but many more weeks will elapse before he will be able to determine correctly any of the different morbid changes in the eye. Dr. Moxon will show him livers and kidneys and lungs, and for a long time he will not know which of them are healthy, and which diseased. The physicians will speak to him of systolic, and presystolic, and diastolic murmurs; but when he applies his stethoscope, he may be unable to recognise any murmur at all; it may be absolutely inaudible to him. If the student be of what I may term an argumentative disposition, he will at first be inclined to dispute the facts—not merely the inferences, but the very *facts*—laid down for him by his clinical teachers.

And when you,—for these difficulties will occur to all of you,—have advanced a little,—when your fingers are beginning to feel, your ears to hear, and your eyes to see,—you will be greatly disheartened by the fragmentary and imperfect character of clinical work. Of one disease you will see the earliest stage, with no prospect of tracing it to its end; of another you will be shown the morbid anatomy, and will only be able to regret that you missed seeing the patient alive; a third will come before you in the middle of its course, and you will be acutely conscious of your powerlessness to tell how it began, or to predict its probable termination.

Gradually, however, these difficulties also will diminish, and sooner or later disappear. As your knowledge increases, you will discover that the range of possible changes and terminations in each class of cases is tolerably definite and limited. In course of time you will less and less frequently find yourselves *taken by surprise* in the progress of disease. You will slowly acquire what I may term a *grasp* of your cases. You will still make mistakes;—it has been said that the only man who makes no mistakes is he who has no patients. You will still often be in doubt; the story goes that a great physician summed up his experience by saying that he was tired of guessing. But notwithstanding your errors, notwithstanding your uncertainties, you will display a power and mastery over your cases, which nothing but clinical study could have given you.

Let me insist on what I have just said. Long, and patient, and repeated clinical study can alone give you such a grasp of your cases as is absolutely essential to your success and comfort in practice. "How," you may reply, "do not some students leave the hospital every year who have spent but very little time in the wards, and of whom the most charitable-minded could hardly say that they ever studied clinically at all? Are these men utterly ignorant, and do they remain so all their lives?" Now, I have not asserted, and do not mean to assert, that bedside work, to be effective, must necessarily be done at a medical school. There are, I know, men of unusual powers, who, their opportunities of instruction having been small, succeed in making their own patients their intellectual food; who, amid all the distractions of practice, systematically teach themselves; and who ultimately reach the highest rank among clinical observers. Such an achievement, however, is quite exceptional; it can never be hoped for in the case of those who, having had all opportunities and means of education, have deliberately neglected or thrown them away.

But you will probably ask me why I thus dilate on the necessity of clinical work *now*, when I am addressing first year's men, who have a crowd of sciences to learn, which are regarded as preliminaries to the study of medicine and surgery. Do I mean that a student ought to attend in the wards from the first day of his entering at a medical school? This is a matter concerning which opinions vary widely, and which is so complicated by a number of considerations, that I can do but scant justice to it on an occasion like the present. It is undeniable that every year some students commit a fatal error by pushing their attendance in the wards and out-patient rooms, so as to neglect their proper work—dissecting, chemistry, physiology. But this does not prevent my thinking that the opposite course is likewise

to their old Alma Mater, were in past years dressers and clinical clerks in this very hospital. They have, perhaps, rarely visited Guy's since they left her twenty or thirty years ago; and as they to-day re-entered her wards, many recollections have crowded upon them. In yonder bed lay the poor fellow on whom Mr. Aston Key performed that great operation, which men from every other hospital came to see! That was the ward to which Dr. Addison came down at three in the morning, waking up the sister, and every one else, because he had been possessed by the fear that he might have overlooked a hernia, in diagnosing a case as one of internal strangulation! Memories such as these, vivid as of yesterday, fill the thoughts of our fathers when they return to Guy's. But some of their cases of last year, or the year before, they would find it very difficult to recall.

There are probably many among my hearers who would wish to ask—now at the commencement of their studies—whether it would be well for them to aim at the degrees of the University of London. This, however, is a matter on which it is difficult to advise—on which, indeed, no general advice can be given. One limit I, for my own part, would, however unwillingly, make absolute. If your education has from any cause been defective, so that matriculation would offer you serious obstacles—if, for instance, you were at all embarrassed by your ordinary preliminary examination—then I have no hesitation in urging you either not to attempt the University curriculum, or to postpone your attendance at a medical school until after you have matriculated. No man, I think, can attend to his medical studies while he is working for the matriculation examination; and I therefore strongly disapprove of a suggestion which has been made, that we should hold classes for this examination at Guy's.

But if your general education has been good—if you have time—and if you have energy and ambition, the University of London is the place for you. It is true that the curriculum is long and arduous. After matriculation nearly four years must elapse, and three examinations must be passed, before the bachelor's degree can be obtained. Those, therefore, whose means are limited, and whose time for study is necessarily short,—those whose noble ambition is held in restraint by a yet nobler spirit of self-abnegation for the sake of others,—ought all, I think, to ponder long before commencing to work for the University.

Or, again, if any one of you be without ambition, if he wish merely to be enabled to carry on with satisfaction to his patients and credit to himself the long-established practice held by his grandfather once, and his father now, in some rural district, he may well be content with the qualifications of the Colleges and the Hall. It may be some consolation to him to be told that there is no surer way to make the public confer on him the title of Doctor, than to call himself plain Mister, and *vice versâ*. But, indeed, I do not presume to offer him consolation; his choice is one which I am far from deprecating;—he, at least, appears to be contented. He may, I believe, acquire just as sound and thorough a knowledge of his profession without a degree as with it.

I desire particularly to impress on you the consideration that a career at the University of London is not to be taken up and laid down at will, without interference with your other studies. The subjects for the earlier examinations are exclusively scientific, and while you are studying them you will have no time for that clinical work on the importance of which I have laid so much stress. Hence, if by any accident you should be thrown back in your course, and your hospital studies should afterwards be interrupted at the end of three or four years, it will, in my opinion, be *worse* for you to be University men. Many London undergraduates have, I fear, been thrown upon their own resources, with but a very imperfect knowledge of medicine and surgery.

The moral I would draw from all this is:—Count well the cost, in time and money, before you aim at the degrees of the University of London. During the four years 1864–8, the degree of Bachelor of Medicine was obtained by less than half (just 45 per cent.)* of those who had succeeded in passing the preliminary scientific examination in the corresponding years. What chance will you have of ultimate success if you are impeded by defective education, by a constitutional want of diligence and energy, or even by circumstances so straightened as to render you only in part masters of your own time?

It ought, in fairness, to be stated, in connection with the remarks which I have just been making, that, compared with the numbers of students entering at the different London hospitals, those who annually pass even the College and the Hall is much smaller than I should have expected. Some facts that I have collected† show that at least one in every five students who enter at Guy's fails to attain the qualification of the College of Surgeons. The various causes of this falling off—death, illness, pecuniary difficulties, dislike of professional work—I have had no opportunities of ascertaining;‡ but

*The numbers are:—

Second M.B. Exam.		Prel. Sc. Exam., 3 years earlier.	
Year.	Number of Candidates who passed.	Year.	Number of Candidates who passed.
1864	26	1861	58
1865	23	1862	63
1866	25	1863	56
1867	22	1864	50
1868	21	1865	33
Total	117	Total	260

† These numbers were obtained by a simple comparison of the entry books at the Hospital, during a term of years, with the pass lists of the College.

‡ Since this lecture was delivered, Mr. Paget has published, in the St. Bartholomew's Hospital Reports (Vol. v., p. 238), a short article entitled, "What becomes of Medical Students?" The facts in this paper are not strictly comparable with mine; but it would appear that among the 1,000 students whose careers were traced by Mr. Paget, at least one in ten failed to become qualified. Of these 41 died during pupilage, 15 never succeeded in passing, 16 were expelled, or removed by their friends, 1 retired on private means, 3 became actors, 6 entered the Army (3 of them as privates), 1 was admitted to the Bar, 10 took to mercantile life, and 3 to farming. The lists, however, from which these facts were taken were themselves not complete; and many of those whose names were included in the lists had been lost sight of, and were therefore omitted from Mr. Paget's calculation. It is evident that among those omitted there would be a *preponderance* of students who, being irregular in their attendance, were but little known to the lecturers and demonstrators, and who would be likely in the end to give up the profession.

it certainly is never due solely to difficulty in passing the examinations, for the licensing boards notoriously exclude no man who perseveres in the attempt to obtain their diplomas.

A point to which your attention ought to be directed before deciding against the University of London is this—that it is now the only source from which a man who has studied in London alone can obtain the M.D. or M.B. degree in Great Britain. A few years ago medical degrees could be procured at more than one Scotch University, by simply passing an examination: but these Universities all now require a year's residence. I have long been surprised that the "Hospital Schools" of London—as these Scotch Universities choose to call institutions like ours—have made no combined effort to remedy a state of affairs which is undoubtedly prejudicial to their interests: namely, that the only University from which their students can obtain the title of Doctor is one of which the curriculum is, to a great extent, prohibitive, as is shown by the fact that only about ten men* annually take the degree of Doctor of Medicine in it, from all the schools in this metropolis together.

I have myself the highest respect for, and take the warmest interest in, the University of London, which, in comparison with the licensing bodies, has done a vast deal to elevate the medical profession, and to improve medical education. But I greatly regret that it cannot open its portals more widely, instead of limiting its benefits to the almost insignificant *number* of students who now have full advantage of them.

It has lately been a question much discussed, whether it would not be possible for the licensing bodies to make examinations the sum and substance, as well as the end and aim, of their requirements.

Mr. Simon has boldly maintained that this ought to be done—that, to use his words, "the State, in licensing a man to practice medicine, besides insisting on a certain standard of age, need only trouble itself with asking whether he is competent, according to a certain standard of competency, and that a perfect examining board would at once be able to settle this question, without reference to any other considerations whatsoever."

Now, theoretically this may be true enough. A *perfect* examining board might perhaps effect all this, separating the chaff from the wheat as unerringly as a steam winnowing machine. But from this point of view I venture to assert that no existing examining board can lay claim to any but the most distant approach to perfection. Regarded as tests whether a man possesses the practical knowledge and skill required to justify him in undertaking the care of the sick, even the examinations of the University of London are, I believe, by themselves altogether inadequate. To make a good practitioner, it is needed, not that a man should know the symptoms, course, diagnosis, and treatment of disease in the abstract, and as laid down in books; but that he should be able to discover what is the matter with his patients, and possess the practical skill required to bring them safely out of their maladies. This, then, is what must be looked to, if the portals of the profession are to be guarded solely by an Examining Board.

But for such a purpose it will, I think, be admitted that examination papers are quite ineffective. Every teacher knows of instances in which men, although devoid of all real knowledge of a subject, have nevertheless written excellent papers on it. In chemistry, almost every student is more or less in this position. What candidate, when examined in forensic medicine, cannot describe accurately the processes by which alkaloids are detected in the contents of the stomach? Yet we should feel great doubts about the adequacy of the investigation in a case of suspected poisoning by strychnia or opium, if the analysis were made even by the most highly educated medical practitioner, unless he should be in the habit of performing chemical manipulations.

The case I have supposed appears to me to indicate the weak point in the position of those who would grant a licence to practise medicine to all who should succeed in passing certain examinations. For although every medical man ought to know the principles of chemistry, it is not necessary that he should be practically acquainted with the more delicate chemical processes.

Mr. Simon, however, and the few thinkers whose views coincide with his, would probably be quite ready to concede that it would be impossible to test a man's real knowledge of medicine and surgery by papers alone. They would rely mainly on those clinical examinations, which, first instituted by the University of London, have been adopted by the College of Physicians, and will no doubt sooner or later be imposed on all candidates for the professional licence. It is usual to extol these examinations very highly, and no doubt their introduction was a step in advance. But in my opinion they would require to be carried much further than has yet been attempted,—and further than would I believe be practicable,—before they could be accepted as conclusive evidence of a man's fitness to practise his profession. For what is the system? Ten, or twenty, or thirty men are taken together to one of the large hospitals. Each of them is then set down before a patient, and is told to examine the case thoroughly, and to write down the results at which he may arrive. The examiners are often unconnected with the particular hospital in which the examination is held, and at any rate they have personal charge of only a fraction of the patients made use of. It is, therefore, impossible that they should have an exact and detailed knowledge of the physical signs and of the other symptoms in each case. And be it observed that the question is not merely whether a candidate can give a name to the disease, but whether he can *observe* with

* The numbers for ten years are:—

1859	11	1864	7
1860	9	1865	15
1861	16	1866	11
1862	6	1867	16
1863	7	1868	7
Total			105

accuracy and precision. A late examiner in the University is reported to have said that in the best commentary on a medical case he had ever read the diagnosis was utterly wrong. The merit lay, I suppose, in the skill with which the candidate reasoned on wrong premises. Now, I maintain that the object of a clinical examination should be to show that the candidate can supply himself with true premises for his argument by his own investigation of a case.

But, gentlemen, the time allotted to me has very nearly expired; the curtain will in a few minutes fall, and I must make my bow and retire, thanking you for the attention you have vouchsafed to my discourse. There are still many subjects on which I would fain have touched, and foremost among them the present position and prospects of the medical art, and its relations to physical science. My own state of feeling in regard to practical medicine is one equally far removed from disbelief in the efficacy of treatment on the one hand, and, on the other hand, from expectation of a millenium in which practice, instead of depending on empirical observation, shall be finally settled on a sound basis of theory and experiment. To a great extent I agree with Sir W. Jenner, who in a recent address expressed the opinion that within the last few years much progress has been made, even in therapeutics. Our knowledge that the tendency of acute disease is to subside spontaneously within no very long period is undoubtedly a positive and real advance of the most important character. This discovery, and the inquiries as to the natural course of chronic disease, have in fact shifted the point of view from which treatment is looked at. Formerly the medical man was content to ask, "Is my patient better than he was a week ago, before he began to take my physic?" Now the question is, "Is he better than he would have been to-day, if he had had no physic?" For the first time in the history of medicine, drugs and methods of treatment have been submitted to that which is the only real test of their value. And with what result? Broadly speaking, with this—that the more active remedies are still believed to possess most of the powers formerly ascribed to them, although advances in pathology and diagnosis have, in some instances, narrowed the range of their use. I quite admit that the applications of the test which I have indicated have in part been crude, and deficient in rigid scientific exactitude. But I think that they have already been enough to warrant a firm belief in the efficacy of remedies.

There still remain, no doubt, a large number of maladies which medicine is powerless to cure, and sometimes, even to relieve. As was well urged by the late Sir John Forbes, man must die, and there must therefore be fatal diseases. Even in so-called functional complaints, you will sometimes be baffled in all your efforts. When this occurs, however, the conclusion which I recommend to you—and which I try to fix in my own mind under similar circumstances—is, not that the pain or other disorder is irremovable, but that *one does not know* how to remove it. A very large part of the unsuccessful practice of the present day arises, I believe, from ignorance of the exact uses and doses of medicines, and of the precise methods of employing them.

In the existing state of knowledge, however, the negative or expectant practice, now so common, is the right practice in a certain number of cases. It is for us, and will be for *you*, to limit these year by year, and to prove that treatment can, in one and another disease, effect more than mere waiting. Above all things, the most to be desired is a clear conviction as to what is, and what is not, known in therapeutics. Even worse than negative practice itself are two of its results or concomitants: the one a spirit of "indifferentism," the feeling that all medicines come to much the same thing, and that one is as good as another—that all diseases, for example, arise from debility, and that therefore tonics are the universal remedy; the other, a state of distrust, a feeling that the power of drugs is open to doubt, and therefore that it is not worth while to make energetic use of them:—

"Our doubts are traitors,
And make us lose the good we oft might win
By fearing to attempt."

Have you yet considered what are the responsibilities of the practitioner of medicine? That to him hundreds and thousands of his fellow-creatures entrust their health, and, indirectly, the prosperity of their wives, and children, and relations?

Shall you bleed? Shall you give wine or brandy? Shall you prescribe antimony, or a purge, or a blister? I verily believe that on your answers to these questions submitted to you perchance when you are worn out with professional cares, or harassed by domestic anxieties—will often depend the life of your patient—his most precious possession. From what pains can you shrink, what labours can you shun, that may give you additional powers of benefiting the sick?

The faithful discharge of your duties, in an earnest, zealous spirit, can alone enable you to touch the prizes that our profession offers. For us there are no peerages, nor any commanding wealth. And of this we cannot complain, for titles and riches are kept from us, not by any social bar, but by the conditions of our work. The real rewards of the physician are the loving gratitude of his patients, the hearty admiration and sympathy of his friends, and the calm, serene approval of his own conscience.

Appointments.

Reynolds, H. D., L.R.C.P. Edin., M.R.C.S. Eng., has been reappointed Medical Officer of Health to the Pembroke Dock Town Council.

Skinner, E. W., M.D. Edin., has been reappointed Medical Officer of Health to the Rye Rural District Council.

Spurrell, Charles, F.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Superintendent at the Poplar and Stepney District Sick Asylum.

Guy's Hospital. Founded A.D. 1722.

THOMAS GUY, at whose "sole costs and charges" this Hospital was founded, was born in the year 1645 in the parish of St. John, Horselydown. At the age of fifteen he was bound apprentice in the porch of Mercers' Chapel in Cheapside to Mr. John Clark, bookseller. In 1668, his apprenticeship ended, he became a Freeman of the Stationers' Company, and of the City of London; and started in business with a capital of about £200, at the "little corner house of Lombard Street and Cornhill." His business flourished, and he gradually acquired wealth. He printed a large number of bibles, having obtained from the University of Oxford an assignment of their privilege; and he was not only a printer but also a publisher of books. In the year 1695 he was returned to Parliament as member for Tamworth, and he subsequently sat in all the Parliaments from the third one of William the Third to the first one of Queen Anne.

In the year 1720 his wealth was increased by the sale of his investments in the South Sea Stock, and he was thus enabled to carry out what appears to have been a long-cherished and carefully considered scheme—the foundation of the Hospital which bears his name. At Christmas of that year he leased for the term of 999 years the ground on which he proposed to build, and during the ensuing year the site was cleared and prepared, and building was begun under the direction of Mr. Stear as architect.

On the 24th of September, 1724, Guy made his will, and on the 27th of December he died in his eightieth year. He survived long enough to see the building completed. In little more than a week after his death the Hospital was opened; and on Thursday, the 6th of January, 1725, sixty patients were admitted. On the 6th of April the first committee of governors was held, and three days later two physicians and two surgeons were formally appointed.

Guy's original building, Guy's House (I. on the plan in front of green book), which is now occupied mainly by the surgical wards, was enlarged by the addition of the East wing in the year 1738, and about thirty years later the West wing was added. In 1744 the lunatic house was built for the accommodation of twenty confirmed lunatics, in accordance with directions contained in Guy's will. In 1859, the governors of the Hospital, in the exercise of their discretion, provided for the reception of its inmates elsewhere, and converted the building to general hospital purposes. It is now known as the Clinical House (II. on the plan in front of green book).

On the 8th of February, 1828, William Hunt, merchant and citizen of London, and for many years an influential governor of the Hospital, added a codicil to his will, by which, after providing for certain annuities and bequests, he left the residue of his property to the "Treasurer and Governors of Guy's Hospital for the benefit and purposes of that institution." In the following year Hunt died, and his estate realised about £200,000, of which £180,000 came to the funds of the Hospital.

In the year 1850 the central portion, together with the South wing of the large structure now known as the Medical Building—or Hunt's House (III. on the plan in front of green book), was begun under the superintendence of Mr. Rhode Hawkins as architect. This building was completed by the addition of the North wing in 1871.

THE MEDICAL SCHOOL OF GUY'S HOSPITAL.

The School of Medicine and Surgery attached to Guy's Hospital may be considered to date its formal commencement from about the year 1769, when a resolution was approved by the Governors to the effect that "All such persons as shall be chosen Surgeons of this Hospital shall occasionally give lectures on surgery to the pupils that shall be entered at this Hospital." A short time before this, however, Dr. Saunders, who had previously lectured on Medicine at his house in Covent Garden, on being appointed Physician to the Hospital, began delivering his lectures here. He may, therefore, be regarded as the founder of the Medical School.

In the year 1768 it was resolved "that the barrier between this Hospital and St. Thomas's be taken down, and that the pupils of St. Thomas's have free leave to see not only the operations, but also all the other practice of this Hospital." Corresponding advantages were afforded to all the Students of this Hospital by the Governors of St. Thomas's. In the year 1825 this union was dissolved, and by a resolution of the Governors of Guy's Hospital the Treasurer was requested and authorised "to make such arrangements as he may find necessary to provide for and place the surgical school of this Hospital in all its departments on the most respectable and efficient footing." In accordance with this resolution a block of buildings (IV. on the plan in front of green book) containing the anatomical theatre, the museum and dissecting-room, was erected at the cost of about £8000. On the 21st of June, 1826, the Treasurer reported "all the school buildings ready and occupied."

In the year 1850 a new dissecting-room, with a demonstrating theatre adjoining, was built, the original dissecting-room being thrown into the museum. In 1871 a new laboratory for the Summer Course of Practical Chemistry was erected, and in 1872 the dissecting-room was enlarged and improved. In the early part of 1878 the museum was extended by the addition of several class-rooms, and in the following year a new mortuary and post-mortem-room were erected.

In 1888 a pathological laboratory was built adjoining the post-mortem theatre, and the accommodation in the physiological department was increased by the erection of two class-rooms provided with the necessary appliances and apparatus.

In 1890 the residential college was opened, having been built and furnished at a cost of £21,000.

In 1892 the Petersham buildings were erected adjoining Petersham House. The block comprises a large and well-lighted chemical laboratory, a lecture-room and laboratories for experimental physics and bacteriology, together with the extensive accommodation required for the Dental School.

Lectures* for Sessions 1895—96.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Clement Lucas and Mr. Lane ...	9	—	Tu	W	Th	Fri	—
Morbid Histology (3rd)	Dr. Pitt	9.30	—	—	—	Th	—	Sat
Pathological Classes (3rd & 4th)	Dr. Shaw	9.30	—	Tu	—	—	Fri	—
Bacteriology (Nov. & Dec.) (4th)	Dr. Washbourn	9.30	—	Tu	—	Th	—	Sat
Medical Jurisprudence (January) (3rd & 4th)	Dr. Stevenson	10	—	Tu	—	Th	—	Sat
Practical Obstetrics (3rd and 4th)	Dr. Horrocks	10.15	—	—	W	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Starling, Dr. Fawcett & Mr. Hopkins	10.30	—	—	—	—	Fri	—
Biology and Botany (pre. sci.) ...	Mr. Beddard and Dr. Stevens	10.30	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.) ...	Dr. Stevenson (October–December) ...	11	—	Tu	—	Th	—	Sat
Advanced Practical Physiology (3rd)	Dr. Starling	11	—	Tu	—	Th	—	—
Public Health (Jan.) (4th)	Dr. Sykes	11.30	M	—	—	—	Fri	—
Practical Medicine (3rd)... ...	Dr. Bryant...	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade ...	12	M	—	—	—	Fri (2)	—
Physiology (2nd)	Dr. Washbourn and Dr. Starling ...	12	M	—	W (11)	—	Fri	—
Clinical Medicine (3rd & 4th) ...	The Physicians	1.15	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Howse & Mr. Davies-Colley (6 weeks each)	1.30	—	Tu	—	Th	Fri	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Dr. Stevens and Mr. Steward	1.45	—	—	W	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Pitt and Dr. Perry	2.30	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Pye-Smith and Dr. Taylor (6 weeks each)	3	M	—	W	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Higgens	3	—	—	W	—	—	—
Practical Surgery (3rd)	Mr. Targett	4	M	Tu	W	Th	—	—
Dental Surgery & Pathology ...	Mr. Newland-Pedley	4	—	—	—	—	Fri	—
Metallurgy	Mr. Groves	4	M	—	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—

SUMMER SESSION. MAY—JULY.

	LECTURERS.		DAYS.					
Midwifery (3rd)	Dr. Galabin and Dr. Horrocks ...	9	—	Tu	W	Th	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Savage	9.30	M	—	—	—	—	—
Morbid Histology (3rd)	Mr. Targett	9.30	M	—	—	Th	—	—
Bacteriology (May & June) (4th)	Dr. Washbourn	9.30	—	Tu	—	Th	—	Sat
Chemistry (1st, pre. sci.) ...	Mr. Groves	10	—	Tu	—	Th	—	Sat
Practical Chemistry	Mr. Groves, Mr. Wade & Mr. Hopkins	10–1	M	—	W	—	Fri	—
Practical Obstetrics (3rd) ...	Dr. Horrocks	10.15	—	—	W	—	—	—
Biology and Botany (pre. sci.) ...	Mr. Beddard and Dr. Stevens	10.30	—	—	W	—	Fri	—
Histology (1st)	Dr. Starling, Dr. Fawcett and Mr. Hopkins	11	—	Tu	—	Th	Fri	—
Practical Medicine (3rd) ...	Dr. Bryant	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade ...	12	M	—	—	—	Fri (2)	—
Operative Dental Surgery ...	Mr. Badcock	12.30	—	—	—	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.30	—	—	—	—	Fri	—
Clinical Gynæcology (3rd) ...	Dr. Galabin	1.30	—	Tu	—	—	—	—
Chemical Physics (1st)	Prof. Reinold	2	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Pitt and Dr. Perry	2.30	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Dr. Hale White	3	M	—	W	Th	—	—
Dental Mechanics	Mr. Wynne Rouw	4	—	Tu	—	—	—	—

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

How to begin Work.

ANATOMY AND THE DISSECTING ROOM.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully indifferent how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the School buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first Winter Session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly, whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the Medical School Office, and any student who is not clear in his mind as to the examination he has to prepare for should read carefully page 64 in the green book.

After the first few days men soon become familiar with the work and learn from one another. But at first they have made no acquaintances and all around them are strangers alike.

Tuesday, October 1st.—There is no actual work done on this day, but each student should pay his guinea for material in the Medical School Office, and take the receipt across to the dissecting-room and present it to the Demonstrators. Then study the red book—which contains the rules of the dissecting-room—and purchase some instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the green book will show them at a glance, and serve as a very efficient guide. During the evening there will be a dinner in the College Hall (admission by ticket, which may be obtained of the Club Steward in the dining hall); and this will be followed by a meeting of the Physical Society of Guy's Hospital in the Anatomical Theatre, to which all new men are specially invited. The programme of this meeting will be found in another column.

Wednesday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture in the Anatomical Theatre, and at 1 o'clock a demonstration is given in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

TO FIND A "PART."

Look down the lists of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with the cloth.

THE REQUISITES FOR DISSECTION.

The following articles are essential and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 18s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street.

b. Books. These are obtainable at Grattan's in the Borough (No. 17). It will be *necessary* to have *Ellis's Demonstrations of Anatomy* (price 9s. 6d.) for use in the dissecting-room, which shows how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Morris and Quain. You will hear their merits compared at the introductory lecture and demonstration—if you are still in doubt consult personally one of the demonstrators, and take any old text-book that you may possess and hope to find of use to him for inspection.

c. An apron and sleeves to keep oneself clean. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose, the key of which is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

HOW TO DISSECT.

The instructions on this point given in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical descriptions depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful art of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and, secondly, to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly NOT the object of dissection to lay bare the bone in the middle of the "part" in the shortest

possible time. That is butchery, not dissection. Remember, then, these few points :—

1. Cut through the skin along the lines given in the books.

2. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

3. Take away the fat carefully without damaging the flesh or muscle underneath it.

4. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks ; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* against it.

5. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the wax model museum preparations.

Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's worktime. Cover the "part" up with a cloth before leaving it for the night.

The red book *containing* the rules of the dissecting-room will be found to contain a lot of useful information and should be read with care, and then kept always at hand.

OSTEOLOGY.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy, it must be learnt practically, by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the Hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second-hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the Second Conjoint Examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is well to have the guidance of a fellow-student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked, and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly ; as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, hence cannot be articulated.

RULES OF THE DISSECTING ROOM.

1. Every first year's student, and every second year's student who has passed the Anatomy, Biology, and Chemistry of the First Conjoint Examination, is expected to attend in the Dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours of 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the Demonstrator in order that the student's name may be enrolled in the appropriate class list. Any second year's student who has not passed the First Conjoint Examination by the commencement of the second Winter Session shall attend for the above purpose in the Dissecting-room within one week of completing that examination.

2. The fee for material (which should be paid in the Medical School Office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is as under :—

WINTER SESSION, or any part of the Winter Session—

First year's students	£1 1s.
Second year's students	
Students senior to the second year, but not yet through the Second Conjoint Examination	
Students going up for the First F.R.C.S. or M.B. of any University	
Students going up for the L.D.S. Examination only	10s. 6d.
SUMMER SESSION.—All students	10s. 6d.

Students entering in January, or those who, having entered in October, have, by permission of the Senior Demonstrator, deferred dissecting till January, shall be allowed to dissect during the Summer Session (subject to Rule 24) without paying any further fee.

3. The Senior Demonstrator (Mr. A. D. Fripp) will meet the first year's students on the second day of the Session at 1 p.m., and give them a demonstration to initiate them into the work of the Dissecting-room. A ballot will be held immediately after this demonstration to determine the order in which parts shall be allotted to students.

4. On the following day the Bone classes, which are held by Mr. Hamilton and Mr. Steward, begin. Every student is advised to purchase a half skeleton and to bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. A student attending the class that is studying (A), (B) or (C) in Rule 8, will either at once or when his turn comes, be allotted a part corresponding with the class work. Should he not be fortunate enough to draw an early

number, he will have the advantage of studying on the skeleton and in the wax model Museum the anatomy of his part before he attempts to dissect it.

5. The Senior Demonstrator will meet the second year's students on the third day in the Session. The Second Conjoint Class demonstrations, given by Mr. Hamilton and Mr. Steward, begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Anatomy, Biology and Chemistry at the First Conjoint Examination.

7. The notice-boards in the Dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the Demonstrators.

8. A written examination is held just before the Christmas Vacation. Every first year's student is required to attend and to answer the questions on one of the following groups—

(A) The bones and ligaments of the head, and the bones, ligaments and muscles of the upper extremity; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments and muscles of the lower extremity; or

(C) *(if he is taking the L.D.S. only)* The bones and muscles of the head and the temporo-maxillary, and occipito-atlanto-axoid joints.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body; and one of the following groups—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax;

(γ) *(if he is taking the L.D.S. only)* The entire anatomy of the head and neck, excluding the brain.

9. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who have shown themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B); but in addition, every student should in this his second part try to master as much as possible of the vessels, nerves, etc.

10. The Senior Demonstrator holds classes throughout the Winter and Summer Sessions for (i.) students preparing for the First F.R.C.S. and M.B. Examinations of the various Universities; (ii.) students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

11. Every student is advised to carry with him when in the Dissecting-room and Demonstrating Theatre a pocket note-book and a set of coloured chalks.

12. Every week the dissections are examined systematically by the Demonstrators, and marks are allotted. The record thus kept of each student's diligence in the Dissecting-room is taken into account in subsequently recommending to appointments in the wards.

13. A test examination is held about three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Conjoint Examination.

14. During the first Summer Session, a student who entered in October, and has passed the Anatomy and Biology of the First Conjoint Examination, should learn the anatomy of the brain, the spinal cord, the heart, the lungs, the larynx and the liver. Demonstrations on these subjects are given in the Demonstrating Theatre at least once a week during the Summer Session.

15. Particulars of the examinations for the Michael Harris, Arthur Durham and Hilton Prizes, and for the First and Second Year Prizes will be found in the Prospectus of the Medical School, which may be obtained in the Medical School Office.

16. About twelve Prosectors to the Lecturers on Anatomy are appointed annually (and from time to time a Prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the Dissecting-room. Notices inviting applications for these appointments are posted in the Dissecting-room.

17. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc., can be obtained from the Dissecting-room Porter.

18. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

19. No limb must be removed from the trunk except by one of the Demonstrators or Assistant Demonstrators: nor in any circumstances must any part of a subject be removed from the Dissecting-room.

20. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to either Mr. Hamilton or Mr. Steward, if he be a first year's man, or to Mr. Fripp, if he be senior to the first year.

21. A subject for dissection can only be provided during the Summer Session if eight students can be found wishing to dissect.

22. The subject is divided into five parts on each side:—

1. The Head and Neck.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax and Spinal Column; the dissection of which is not to commence until the fourteenth working day.

23. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

24. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the Dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice *in writing* to one of the Demonstrators, who will make arrangements for its disposal. The Demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

25. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the Dissectors may have it turned back. The time of day for the dissection of the perinæum is before 11 a.m., unless by special arrangement among the students dissecting the subject.

26. The Dissecting-room is open from 9 a.m. till 4.30 p.m. except on Saturdays, when it is closed at 2 p.m.

27. On applying at the Medical Office a locker may be obtained for a deposit of Five Shillings, which will be returned when the key is given up, provided that the locker is uninjured.

DENTAL STUDENTS.

During their first Winter Session dental students are expected to dissect the head and neck and to study the bones and muscles of the head with the temporo-maxillary and cervical articulations upon which they are examined at Christmas. In addition, they should become acquainted with the main vessels, nerves, and special structures of these regions.

A dental student, on entry, must pay the fee for material at the Medical School Office, on October 1st, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Fripp to first year students, on Wednesday, October 2nd, at 1 p.m.

Special bone classes are held for dental men, commencing early in November, the times of which will be duly announced on the notice-board in the dissecting-room.

It is very essential that the study of anatomy, physiology, and surgery, should be prosecuted energetically from the outset: thus obviating the necessity for "cramming" these subjects when preparing for the final L.D.S. examination.

PHYSIOLOGY.

During the first Winter Session, read Huxley's *Elementary Lessons in Physiology*. Those who already know some Anatomy or Biology may replace this by Starling's *Physiology*.

In the first Summer Session, attend the Practical Histology class, and read the subject in Schäfer's *Essentials of Histology*. For this class students must supply themselves with a compound microscope and mounting materials. The microscope must be approved of by the Demonstrators. It is no use bringing up an antique instrument that may have formed part of the furniture of the Ark, nor can a proper instrument be bought at the stores or the family grocers. Those who can afford it should bring a Zeiss' microscope (about £10). Cheaper, but quite reliable instruments, can be obtained from Ross, Swift, or Leitz, for between £6 and £8. The microscope should have two objectives, $\frac{2}{3}$-inch and $\frac{1}{6}$-inch. The demonstrators will be very glad to advise any student with regard to the choice of a suitable microscope. The mounting materials will cost about 10s., and can be procured from Stanley's, on the London Bridge Railway Approach. A list of the requisite apparatus may be had at the School Office. Those who intend taking the London M.B. or the F.R.C.S., should also read the Histological part of Quain's *Anatomy*. In the second Winter Session the Physiology lectures must be attended. At the same time the subject must be attacked in earnest by reading, and the best book is probably Waller's *Human Physiology*. Those who find it too difficult, may read instead Yeo's *Manual of Physiology*, which is extremely clearly written, and is, perhaps, the easiest of all the reliable text-books.

During the latter half of this Session, students must attend the practical classes held once a week in Chemical Physiology. It would be useful, in connection with these classes, to study Halliburton's *Essentials of Chemical Physiology*. During this Session most men will also attend the Revision Classes, held in preparation for the Examination of the Conjoint Board.

For London University men the course must be somewhat modified. They should read Waller, Bunge's *Physiological Chemistry*, and certain parts of Halliburton's larger work. Histology and Embryology should be read in Quain's *Anatomy*.

During the whole of the second Winter Session they should attend the class in "Advanced Practical Physiology," and in the second summer the revision classes held in preparation for the Intermediate M.B. Those

who intend trying for Honours should supplement this course of reading with some of the more important papers which have appeared in the *Journal of Physiology*, and should pay especial attention to Histology and Practical Histology. Gamgee's *Physiological Chemistry* may be also strongly recommended to those interested in the subject. Candidates for the F.R.C.S. should remember that this is a severe, but not an advanced examination. They may read the same books as are recommended for the ordinary men, but they must know their subject, and especially their Histology and Embryology very accurately. It is advisable for them to attend the advanced classes in Practical Physiology.

S.

BIOLOGY.

The course of lectures and demonstrations for the requirements of students preparing for the First Conjoint Examination, is given in the Physical Lecture Theatre, in the Dental School Buildings, at 1.45 on Wednesdays and Fridays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the *very first*, to obtain the knowledge in Biology requisite for the Conjoint Examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly not of much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of Morbid Histology and Bacteriology.

The first lecture will be given in the Physical Lecture Theatre on *Friday, October 4th.* For the practical class the requisites, of which a complete list is given below, must be obtained *beforehand.* We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration in entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators. Work will be commenced upon the "Dog Fish."

The special course of lectures and demonstrations devoted to the Preliminary Scientific Examination of London are held on Wednesdays and Fridays at 10.30 a.m. The first lecture will be given by Mr. Beddard on Wednesday, October 2nd, in the Biological Class Room, No. IV., on the first floor of the Pathological Museum block of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing "a dissecting case," students must understand that an ordinary (human) anatomical set is *all* that is required. The special "biological" set is by no means necessary for the elementary work required at Guy's, and is, therefore, a needless expense. The other accessories are to be obtained of Stanley, Railway Approach, price 20s.

REQUISITES FOR THE PRACTICAL BIOLOGY CLASS.

Every student attending these classes must provide himself with a microscope with a double nose-piece, and indicator fitted in eye-piece. Zeiss's stand vi., in mahogany case, with objectives A and D, and eye-pieces 2 and 4, and nose-piece, price £8 15s. Illuminators are 22s. extra. This is very strongly recommended. To be obtained of R. Kanthack, 21, Golden Square, Regent Street, W., Messrs. Baker, High Holborn, or of Stanley, London Bridge. English patterns may be obtained of Messrs. Beck, Ross or Swift. A stoppered bottle (with glass rod) containing Canada Balsam, dissolved in xylol; a stoppered bottle containing xylol; three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section-lifters; three needles in handles; a pair of microscope scissors (curved on the flat); ½-oz. No. 1 ¾-inch cover glasses; a gross of glass slides; a packet of labels; a small piece of soft silk; fine curved forceps; a "Seeker"; an anatomical dissecting case; a razor for cutting sections.

CHEMISTRY AND PHYSICS.

No real knowledge of Chemistry or Physics can be acquired without personal and practical acquaintance, and Guy's men have, in the New Laboratories, every facility for this purpose.

Conjoint men entering now should pass in Chemistry and Physics next July. They should, therefore, attend Dr. Stevenson's Lectures in Chemistry from October to Christmas, and Mr. Groves' from May to July, and, concurrently with the latter, Prof. Reinold's Lectures in Physics. They must be prepared to devote a large amount of time to Laboratory work. From May to July the Practical Classes are held on three mornings a week (Messrs. Groves, Wade and Hopkins), but students are advised to work also at intermediate times. Revision classes are held before the July examination, and special courses for referred students before those in January and April. Conjoint students are not required to study Chemistry or Physics after passing the first examination, unless they wish to take the diploma in Public Health, but for this latter purpose they must work for three months at water and gas analysis, etc., in the Public Health Laboratory (Mr. Hopkins).

Dental students are required to work for three months at Practical Chemistry (Mr. Wade, January to March), and to attend the same lectures as the Conjoint men.

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University are recommended to devote a large amount of time to Laboratory Work. The lectures in Chemistry are the same as for the Conjoint students, but those in Physics are specially arranged (Mr. Wade, M. Th. 2—4), and twice a week in the Physical Laboratory (Prof. Reinold and Mr. Wade, Tu. 2—4; F. 3—4), but students are expected to

work in the Laboratories at intermediate times. Tutorial Classes are held once or twice weekly in each subject, and Revision Classes during the term preceeding each examination. Students intending to work for Honours in either subject should consult the demonstrators.

Intermediate M.B. men who have just passed the Preliminary Scientific examination should begin to work at Organic Chemistry next May. The Practical Class meets twice a week in the Laboratory throughout the year, and is supplemented by lectures (Oct.—Dec., Mr. Wade, W. at 10; May—July, Mr. Groves), and by Revision Classes. Students intending to present themselves next July should have worked through three courses by that time, those who attended the course last summer, for instance, requiring to work for three months this winter and three months next summer. Candidates for Honours next July should resume Laboratory work at once. A course of Advanced Lectures for Honours men will be given by Mr. Wade during the latter part of the Winter Session and the Summer Session.

Oxford, Cambridge or Durham students desiring to work at Chemistry should communicate with the demonstrators.

The practical knowledge of Toxicology required at the Degree Examinations of the London and other Universities may be obtained at Classes held by Dr. Stevenson and Mr. Hopkins during the latter part of the Winter and the Summer Sessions. W.

PRACTICAL PHARMACY. MATERIA MEDICA.

These subjects are taught in the Practical Pharmacy Class at the Hospital Dispensary by Mr. Collier. This course meets the requirements of students preparing for the Conjoint Examination in Practical Pharmacy, and the Intermediate M.B. Lond. The study of the names, physical characters, and chemical properties of substances used in medicine, the preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *viva voce* examinations, in acquiring a sound knowledge of Materia Medica. The art of dispensing, the writing of prescriptions, and the methods of prescribing drugs, form also part of the instruction given in the Practical Pharmacy Class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

PHARMACY, PHARMACOLOGY, AND THERAPEUTICS.

Lectures are given during the Summer Session in the Anatomical Theatre by Dr. Hale White. This course is intended to meet the requirements of students preparing for the Third Conjoint Examination in Pharmacology and Therapeutics, for the Intermediate M.B. and Final M.B. Lond., and the Third M.B. Cambridge. C.

BACTERIOLOGY.

The following are the arrangements for the study of Bacteriology:—Two sets of lectures are given during the year; the one in the second week of November, and the other in the middle of May. The lectures are given three days a week, and each course lasts about six weeks. Practical classes, in which the students are taught the technique of staining and cultivating bacteria, the bacteriological examination of air, water, food, etc., are given immediately after each lecture. During the period when the lectures are being given the Laboratory is open every day to those who have joined the class. Gentlemen who have attended a practical class can, by application to the Demonstrator, obtain permission to perform original investigations at any time.

MEDICINE.

Medicine lectures are held on Mondays, Wednesdays, and Fridays, at 3 p.m., in the Anatomical Theatre, throughout the Winter Session, by Dr. Pye-Smith and Dr. Taylor. The introductory lecture will be given by Dr. Pye-Smith, on Wednesday, October 2nd, who will then proceed to discuss "Fever, Contagion, and Specific Diseases."

A Clinical lecture is delivered every Saturday, at 1.15 p.m., in the Chemical Theatre, the first of which will probably be given by Dr. Taylor, on Saturday, October 5th. These lectures are held at 1.15, so as to enable footballers to attend, and they finish in time for them to catch the 2.35 train to Honor Oak Park.

In addition to the above course, Dr. Shaw holds Revision Classes for six weeks before the Final Conjoint Examinations in January, April and July, for the benefit of students desirous of presenting themselves for the Final Examination in Medicine.

THE MEDICAL WARDS.

Clinical Instruction in Medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the Physicians, who visit their cases from 2 to 5 p.m., and by the Medical Registrar in the mornings from 10 a.m. to 1 p.m. There are two male wards, Philip and Stephen, each containing forty beds, and one female ward, Mary, containing fifty beds and six cots. The latter is divided into four divisions, each Physician taking one division. Dr. Pye-Smith and Dr. Goodhart divide the beds in Philip ward between them, and Dr. Taylor and Dr. Hale White, those in Stephen ward. On Mondays and Thursdays the wards are visited in the afternoon by all the Physicians; on Tuesdays by Dr. Goodhart and Dr. Hale White; on Fridays by Dr. Taylor, Dr. Goodhart and Dr. Hale White, and on Saturdays by Dr. Pye-Smith. The Medical Registrar sees new cases in all the wards on Monday and Thursday mornings; on Tuesday, Dr. Taylor's cases; on Wednesday, Dr. Goodhart's; on Friday, Dr. Pye-Smith's, and on Saturday, Dr. Hale White's. Thirty-six medical ward clerks are appointed

every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties

1. *Case-taking.*—Reports are made by the medical ward clerks on all the cases admitted to the wards, under the supervision of the Medical Registrar, who instructs the clerks in the mornings, in the method of case-taking, and the physical examination of patients. Special report sheets are kept for this purpose in the wards; on the front page, spaces for the name, age, occupation, address of patient, ward, number of bed, physician, date and references to former admissions, if any, must be filled in; the report itself must be then started on the next page, by recording the most prominent symptoms for which the patient was admitted, *e.g.*: "The patient was admitted for hæmoptysis, ascites, vomiting," or as the case may be. If the patient has been an in-patient before, the old report must be looked up in the Registrar's room, which is in the new building, on the right-hand side of the stairs leading to the medical wards, the key of this room being hung up behind the door of the Eye wards opposite. Since the year 1888, an index of all the patients' names has been made a separate volume for each year, and they will be found in this room on the table. Having found the patient's name, a letter and a number will be found after it, the former is the initial letter of the Physician, the latter the number of the report in that Physician's volume of reports for that year, *e.g.*: if a patient had been in the medical wards in 1890, and the name is found in the index with P.S. 100, after it, it would mean that he was under Dr. Pye-Smith, and his report would be number 100 in Dr. Pye-Smith's volume of reports for 1890. The clinical reports for the year are all bound together, and the letter C refers to the clinical volume.

If the patient has been in the Hospital before, during the current year, his report can be obtained by applying to the Medical Registrar. If he comes under the same physician the report must be continued; if under a different physician, an extract must be made and a new report commenced.

Before the year 1888 an index of names will be found at the commencement of each volume.

The old report having been found, an extract must be made, and the diagnosis then arrived at inserted in the new report. The condition of the patient since his last discharge from the Hospital must then be noted: then the commencement of the present illness, with the symptoms and the date (not the name of the day only) of their onset, and the treatment before admission. Supposing there has been no previous admission, after stating the leading symptoms for which the patient was admitted, a description of his previous manner of life, occupation, travels, etc., must be noted, then his family history, especially in diseases of the nervous system, gout, rheumatism, phthisis, etc.; then a history of previous illnesses, with dates, and then of his present illness, as above described, and lastly, the condition on admission; this last-mentioned is the most important, and should be done as soon as possible. If the clerk has not seen the case on admission the necessary details may be obtained from the House-Physician. The condition on admission should be commenced by noting the pulse and respiration rate, and the temperature and general appearance of the patient; this should be followed by a description of the system primarily affected, then the system most likely to be affected by complications, *e.g.*, in a case of acute rheumatism first describe the articular, then the circulatory, respiratory, cutaneous, alimentary and nervous systems. When describing physical signs the results of the examination should be arranged as far as possible under the headings Inspection, Palpation, Percussion and Auscultation, and it should always be remembered to use the eyes before the hands, and the hands before the stethoscope. In acute cases a daily record of the physical signs, symptoms, and the general condition of the patient must be kept. In renal cases a daily examination of the urine must be made and the result noted on charts provided for this purpose. In all cases the treatment written on the bed letters must be copied into the reports. Observations made by the Physicians on their rounds should be reported, great care being taken not to misinterpret them.

When the patient leaves the Hospital a description of his condition on the day of discharge must be noted, and the report concluded with a short epitome of the leading features of the case. If the patient dies, an abstract of the post-mortem report, which can be obtained in the post-mortem room, must be inserted. When the report is completed, it must be taken to the Medical Registrar's room.

2. *Temperatures.*—The temperature of the patients must be taken and noted every morning by their respective clerks. Evening temperatures are taken by the clerks in turn; the dates of this duty will be found on the notice-board in the central hall of Mary ward. The temperatures to be taken will be put on a card hanging on the wall in each division.

3. *Classes.*—On Thursdays, classes are held for all the medical ward clerks at 12 o'clock, in the surgical class room, on the application of anatomy to medicine, the methods of medical diagnosis, and the explanation and interpretation of physical signs. On Mondays, at 12.15, classes are held in the clinical laboratory for Dr. Goodhart's and Dr. Hale White's clerks; and on Tuesdays at 2 o'clock for Dr. Taylor's and Dr. Pye-Smith's clerks, when practical demonstrations on the examination of urine, blood, sputum, etc., and on the use of the various instruments required for clinical investigations are given by the Medical Registrar.

4. *Beds.*—The arrangement of beds will be found on the notice-board in Mary ward.

5. *The Clinical Laboratory* (door opposite the lift in the new building), is open to medical ward clerks between 10 and 1, for any special clinical investigation and for the examination of sputum. The key can be

obtained from the Medical Registrar, to whom also application for any special apparatus or reagents must be made.

6. *Medical Instruments.*—Instruments for clinical investigations — hæmocytometer, hæmoglobinometer, perimeter, spectroscope—are under the charge of the Medical Registrar, and can be obtained from him on application.

A few practical hints:—Medical Ward Clerks should, first of all, make themselves familiar with the normal physical signs, *e.g.*, the normal shape of the chest, the normal vesicular murmur, the normal cardiac sounds, etc., and then with the physical signs of disease, their mode of production and their special import. It will be found useful, first of all, to read a book on physical diagnosis, such as Fenwick's *Medical Diagnosis*, or Gibson and Russel's *Outlines of Physical Diagnosis.*

As a text-book Taylor's *Medicine* cannot be improved upon. Do not start at the first page and read straight through; read up and endeavour to understand your own cases. When this has been done, use your colleague's cases in the same manner. *Do not be rough with your patients; percuss and palpate gently. Do not sit up a patient suffering from Typhoid to examine his back. Do not percuss the chest of a patient suffering from Hæmoptysis. Do not test the knee-jerks of a patient suffering from Acute Rheumatism; and if you sit on his bed, look before you sit. Do not discuss with your colleagues in the patient's hearing the prognosis of the case if it be serious, or the probable post-mortem appearances of his organs. If possible, imagine yourself in your patient's position, and then you will treat him with consideration.* M. R.

MORBID HISTOLOGY.

These classes are held by Dr. Newton Pitt, in Class-room No. 2, on Thursdays and Saturdays at 9.30 a.m., commencing on Saturday, October 5th. Sections are given out ready to be mounted, illustrating the more important lesions of the liver, kidneys, spleen, adrenal bodies, alimentary canal, lungs, pleuræ, brain, and spinal cord. Three or four specimens, together with a short written description, are given out each morning. These are examined, and the demonstrators point out the important features in each section. Each student must make a sketch or diagram indicating the changes illustrated by each section, and the sizes of the various elements are measured by the eye-piece micrometer. It is important that students should all be provided with the micrometer before the first class, in order that the values of the divisions may be determined for them then.

Each student attending these classes must be provided before the first meeting with a text-book on *Pathology*, by Dr. Sims Woodhead or by Dr. Green; a microscope fitted with a double nose-piece, and two objectives, viz., an inch, and a higher power, either a quarter or a sixth. Also the following accessories, which may be procured from Messrs. Stanley: An eye-piece micrometer, cost half-a-crown. This must be fixed in so that the lines are accurately in focus when an object in the field is clearly seen; the values of the divisions will be determined at the first class. A glass-capped bottle with glass rod, filled with Canada Balsam dissolved in xylol; a wide-stoppered bottle, with clearing fluid, either oil of cloves or a mixture of carbolic acid and turpentine; a capped bottle of Farrant's solution; two small saucers with flat bottoms; a watch-glass; half an ounce of square cover glasses, $\frac{7}{8}$-inch; a gross of glass slides; a packet of small filter papers; two lifters; two needles in handles; a box to hold twelve dozen slides horizontally; a note-book; H.B. black pencil and a red pencil; an old linen handkerchief. Dr. Pitt will be glad to advise those students who require to buy a microscope. P.

SURGERY.

Lectures are held three times a week, on Tuesdays, Thursdays and Fridays, at 1.30 p.m., in the Anatomical Theatre, by Mr. Howse or Mr. Davies-Colley. Mr. Howse for the first part will lecture on "General Surgery," commencing on Thursday, October 3rd. Clinical lectures are given on Wednesdays at 1.30, in the Anatomical Theatre, by the Surgeons. The first will probably be given by Mr. Davies-Colley, on Wednesday, October 2nd.

Mr. Targett holds classes in "Practical Surgery" four times a week in Class-room No. 1. These classes are open to men in their third year, and must be attended to fulfil the requirements of the Conjoint Examining Board. A list will be posted in the colonnade, giving the names of those who are not yet "signed up," with the days on which they are expected to attend.

Mr. Dunn, six weeks before the Final Conjoint Examinations in January, April and July will hold "Revision Classes," upon which attendance is voluntary. Only those desiring to present themselves for examination are expected to attend.

Mr. Dunn will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1896. Names of students desirous of attending the M.B. course should be left at the Medical Office *before* the end of September. Mr. Higgens will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 3 p.m., in the Ophthalmic Operating Theatre. These lectures must be attended after passing the Second Conjoint Examination before admission to the Final Conjoint.

THE SURGICAL WARDS.

In the Surgical Wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as a clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He

will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the Hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others to belittle the post. This is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical, the preparation of the permanent Hospital records of the cases admitted to the wards. What difference there is consists of this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical wards falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has, on the whole, been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the Hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the Hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In this nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of a clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm as a whole should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that his reports are not below the level of those of other firms. Their accuracy is, of course, of the highest importance to him. They represent the work of the firm, and the individual members should see that they give a fair and accurate idea of that work. The clerk from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. See that he represents it fairly.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration râles, and condition of the urine, must be notes of every case on admission. The surgical registrar sees every new case with the clerk, and he expects a history of every case to be ready when possible. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. This exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon and dresser. This should be copied into the report as soon as possible.

The duties appertaining to each appointment are supplied to the students, and then are to be carefully followed out. The Hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post he holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the Surgeons and Assistant Surgeons, at 1.30. Tuesdays and Fridays are reserved for operations, notice of which has been posted in the colonnade. The surgeons are assisted at the operation by the dressers, and no others should stand about in the well of the theatre, the only exception being the particular ward clerk to the case. With due diffidence we should like to hint that the front seats reserved for the Staff and for visitors were never intended to be used as a footstool. The habit of sitting perched along the front rail is one of recent growth only, and in the

interest of the patient, the operator and those watching the operation is to be deprecated.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialisation has provided a clerk responsible for the drawing up of the Hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the same time being dependent on the others for the smooth, even working of the whole. S. R.

ANÆSTHETICS.

Lectures and Demonstrations are given by Mr. Tom Bird and Dr. Silk on the use and administration of anæsthetics; they are open to men who have passed the Second Conjoint Examination or its equivalent, and to Dental students in their second year. The post of "Anæsthetic Clerk," of one month's duration, is open to students only who have attended the Lectures and Demonstrations.

DENTAL SCHOOL.

Perhaps the greatest of the many advantages that dental students of Guy's Hospital possess, is that all the special and general lectures can be attended, and the practical work done, at one school.

There is no waste of energy, or of time, such as must necessarily arise if a student is compelled to divide his work between a dental and a general hospital, the positions of which are in many instances miles apart.

It, therefore, follows that if a man conscientiously applies himself to his duties, with the full determination of making the most of his two years' practice, that the opportunities afforded at Guy's cannot be surpassed anywhere.

In order that a student may know how to begin his studies without any delay, it is well to give some few words of advice upon *Instruments*, *Conservation Room Dresserships*, *Probationary Work*, *Dissections*, *Lectures*, *Note-taking* and *Text-books*.

Upon joining the Hospital every student is supplied with a list of *Instruments* required for conservative operations. This list is fairly comprehensive, and all the instruments, including the dental engine, will be useful in private practice, when qualified. A cabinet containing these tools can be obtained at any of the dental depôts, and it should be purchased without a day's delay. The member of the Staff to whom the student is first appointed as Conservation-room Dresser will kindly inspect them, and certify, if correct.

In passing, it may be stated that at the beginning of January, May and October, the students are appointed to the Surgeons as *Dressers in the Conservation Room*, and are required while holding the appointment to attend their Surgeons on their visits to the Hospital.

The *Probationary Work* should be executed, under the supervision of the House-Surgeon, as soon as possible; for the care of patients is not entrusted to a student until he has satisfied the Dental Staff that he has acquired some proficiency in doing gold fillings and crowns in teeth which have been removed from the mouth.

As the probationary work does not occupy a man's whole time, and as he is not permitted to operate upon patients for the first few weeks (as just stated), it is important that he should begin immediately his *Dissections*. This is particularly recommended, as dissections and operations upon the living subject are most inadvisable at the same time, on account of the possibility of septic infection. It is for this reason that an interference with dental practice is caused, if dissections are put off until later in the Session.

All students are supplied with a Prospectus containing the rota of *Lectures*. The lectures for the Winter Session are:—Metallurgy, Mondays, at 4 p.m.; Dental Anatomy, Wednesdays, at 4.30 p.m.; Dental Surgery, Fridays, at 4 p.m. It is advisable for students to be in their places a few minutes before the lecture begins.

Note-taking may be judiciously employed, as it tends to impress the subject upon the mind, and the notes are available for reference; but it is not necessary to attempt to take down the lectures verbatim, unless a knowledge of shorthand has been acquired.

The *Text-books* upon the general subjects—Anatomy, Physiology, Surgery—are the same as those used by medical students. The *last editions* of "Tomes' Dental Anatomy (1894)," and "Tomes' Dental Surgery (1887)," should be bought. The purchase of other works can be deferred until they are recommended by the lecturers upon the different subjects.

If in doubt as to the necessity, or advisabilty, of adding a book to your own library, make some acquaintance with the work by referring to it in Guy's Library.

When not engaged in any of the foregoing ways, much may be learnt by attendance upon the practice of the Dental Staff in the *Out-patient Department*, where interesting cases are daily to be seen.

If any further advice, or help, is needed, it will be gladly given at all times by any of the dental officers.

M.

THE COLLEGE.

The idea of a Residential College at Guy's, although first projected in the days of Addison, was not carried into effect until 1890, when, built upon a site fronting the east gate of the Hospital, and connected therewith by a subway, the College was opened in March by Mr. Gladstone. Residence is afforded here for the men holding the senior house appointments and for about fifty other students, who are all under the supervision of the resident warden, Mr. Dunn. Particulars as to

terms may be seen on page 25 of the green book. There are a few vacant rooms, for which applications should be made to Mr. Croucher at the Medical School Office.

The College contains also the premises of the Students' Club, in the reading-room of which there is a Lending Library.

Guy's Hospital.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Pye-Smith (1.30), Mondays, Thursdays, and Saturdays. Dr. Taylor (1.30), Mondays, Thursdays, and Fridays. Dr. Goodhart (1.30), Mondays, Tuesdays, Thursdays, and Fridays. Dr. Hale White (1.30), Mondays, Tuesdays, Thursdays, and Fridays.

Surgical Wards.—Mr. Howse (1.30), Wednesdays and Saturdays. Mr. Davies-Colley (1.30), Mondays and Thursdays. Mr. Lucas (1.30), Mondays and Thursdays. Mr. Golding-Bird (1.30), Mondays and Thursdays. Operations (1.30), Tuesdays and Fridays.

Obstetric Wards.—Dr. Galabin (1.30), Mondays and Fridays. Dr. Horrocks (1.30), Tuesdays and Fridays.

Ophthalmic.—Mr. Higgens (1.30), Fridays. Mr. Brailey (1.30), Tuesdays. Operations (1.30), Mondays and (2), Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the Hospital are as follows:—

Medical Cases.—Dr. Pitt (12.30), Mondays. Dr. Shaw (12.30), Fridays. Dr. Washbourn (12.30), Wednesdays.

Surgical Cases.—Mr. Jacobson (12.30), Wednesdays. Mr. Symonds (12.30), Thursdays. Mr. Lane (12.30), Mondays. Mr. Dunn (12.30), Saturdays.

Obstetric.—Dr. Horrocks (12.30), Thursdays and Saturdays.

Ophthalmic.—Mr. Higgens (1.30), Tuesdays. Mr. Brailey (1.30), Tuesdays and Fridays.

Dental.—The Dental Staff (9), every week-day.

Aural.—Mr. Purves (1), Tuesdays.

Skin.—Dr. Perry (1), Tuesdays.

Throat.—Mr. Symonds (2), Fridays.

Electricity.—Dr. Pitt (10.30), Tuesdays and Fridays.

The entrance for Out-Patients is in GREAT MAZE POND. A charge of threepence is made for Medicine, and patients must bring their own bottles and gallipots.

No letters of recommendation are required.

BRITISH WORKMAN TO ONE OF THE STAFF: "Can you tell me which is the Theological Laboratory?" "No, but I can show you the Bacteriological Laboratory." "Ah, that's it. That's what I want."—A fact.

The Arthur Durham Memorial.

IT is proposed to raise a fund of £2,000 to endow in perpetuity two beds in memory of the late Mr. Arthur E. Durham. The following is the seventh list of subscriptions.

In consequence of representations which have been made that many gentlemen returning to town would be glad to secure a copy of the mezzotint portrait of Mr. Durham, specimens of which are to be seen in the Library and College, the committee have reconsidered their previous decision and will keep the subscription list open for *another fortnight.*

All subscribers of one guinea and upwards will receive a copy of the portrait.

	£	s.	d.
Amount previously acknowledged ...	1,654	9	0
Executors of the late Mrs. Campbell, of Norwood, per A. H. M. Saward, Esq. ...	50	0	0
Burdett, H. C., Esq., Porchester Square ...	10	10	0
Batten, J., Esq., the College	5	5	0
H. C.	3	3	0
Elphinstone, R., Esq., Towcester	2	2	0
A. H. S.	2	2	0
Forman, E. B., Esq., M.D., 11, Bramham Gardens, S.W.	2	2	0
Trewhella, H. E., Esq., M.D., Saltash ...	2	2	0
Campbell, H. J., Esq., M.D., Welbeck Street, W.	2	2	0
Prier, S., Esq., Brockley	2	2	0
Counsell, H. E., Esq., Liss	2	2	0
Larkin, F. G., Esq., Grove Park, Kent ...	1	1	0
Ogle, C. J., Esq., 1, Cavendish Place, W. ...	1	1	0
Parry, R., Esq., M.B., Carnarvon	1	1	0
Browne, Chas., Esq., 11, Moorgate Street ...	1	1	0
L. D. T.	1	1	0
Manser, T., Esq., Tunbridge Wells	1	1	0
Risdon, W. E., M.D., Barnes	1	1	0
Rouw, R. Wynne, Esq., 7, Wimpole Street...	1	1	0
Manning, T. D., Esq., M.B., Guy's	1	1	0
Charles, H. E., Esq., Swansea	1	1	0
Rake, H. V., Esq., Fordingbridge	1	1	0
Frith, W. S., Esq., M.B., Hospital Ship, Dartford	1	1	0
Bolus, H. B., Esq., M.B., Beckenham ...	1	1	0
Fremantle, F. E., Esq., Guy's	1	1	0
Bunting, J., Esq., Earlham, Torquay ...	1	1	0
Grove, W. R., Esq., M.B., St. Ives, Hunts ...	1	1	0
Metcalfe, G. H., Esq., Clare	1	1	0
Spurgin, W. H. Esq., Northampton	1	1	0
Webb, W. H., Esq., 31, Old Jewry	0	10	0
Per H. Millson, Esq.—			
Gilbert James, Esq.	1	1	0
Per T. M. Nicholson, Esq.—			
T. M. N.	2	2	0
Instone, B., Esq.	1	1	0
Nicholls, F. J., Esq.	1	1	0
Rayson, H. K., Esq.	1	1	0
Hancock, W. I., Esq.	1	1	0
X. E. R.	0	10	0
Cann, F. J., Esq.	0	5	0
Clowes, E. F., Esq.	0	5	0
W.	0	2	6
Per C. E. Carpmael, Esq.—			
Desprez, H., Esq.	1	1	0
Dolman, A. J., Esq.	1	1	0
	£1,768	0	6

Passim.

A HEARTY WELCOME TO YOU ALL,
AND
THE MORE THE MERRIER.

ATTENTION is again drawn to the House Dinner, at which Dr. Pye-Smith will preside, to be held at 6 p.m., on Tuesday, October 1st. Arrangements have been made for 110 guests, and intending visitors should quickly make sure of the few remaining seats.

FRESHMEN will have an opportunity at the Exhibition, on the opening meeting of the Physical Society, of inspecting many of the books and instruments which the various Lecturers and Demonstrators have thought fit to recommend in this issue.

DR. FAGGE'S lecture—eminently suited to the occasion—needs no introductory words from us: its very motto, "Ab Tuitio," cannot of course be too frequently impressed upon all those who now, for the first time, find themselves atoms of the huge molecule of Guy's, and especially valuable will be found the counsel with regard to the advisability of attempting the London University Degrees. There is, perhaps, one thing in which we must beg to differ with our illustrious teacher, and that is, in the questionable advantage of commencing clinical study as a first year's student—no doubt in 1869 we should have agreed with him—similarly in 1895 we venture to think he would agree with us. Time has altered this; in 1869 a three years' curriculum was the common period as compared with our five years' course, which allows more time for clinical study; and again, the greater perfection of instruments such as microscopes, ometers and graphs innumerable have multiplied to an unthought of extent the paths in the maze of Physiology and other "preliminary sciences." Notwithstanding these opinions—matured by years—we shall expect to see the same crowding of the operating theatre and out-patients as in last October and many preceding years, lasting, it is true, for the majority but a few days, by which time the wise have discovered the unprofitableness of watching at a distance operations on parts of which the anatomy is to them still hidden, or of listening to differential diagnoses of cases where "symptoms" or "physical signs" are wonders and discoveries of the dim future.

WITH much pleasure we publish Mr. Briscoe's letter in another column, and trust that his suggestion with regard to a suitable wedding present to Mr. Lucas will be well taken up by Leucocytes, past and present, and other Guy's men.

MUCH wonder has been expressed that so few men attempted to avail themselves of an opportunity—possibly the last before the fives court is pulled down—of taking part in the Fives Tournament which had been arranged, but has had to be abandoned owing to lack of competitors. Could not another effort be made when the Session has begun?

IT is to be hoped that the example of Mr. A. H. M. Saward will find many imitators. Owing to his perspicacity the Arthur Durham Fund has been lately benefited to the extent of a legacy of £20.

WE learn that after the draw for the first round of the Surrey Senior Cup, we shall meet Kingston-on-Thames, on Saturday, November 9th. Therefore, Association XI., train hard, buck up, and beat 'em.

WE also notice the names of N. Lavers, F. E. Walker, and R. T. Fitz-Hugh, as chosen to

represent the Surrey Second Team v. Middlesex, on October 16th, at Denmark Hill.

It is our pleasing duty to record the following Appointments:—Dr. T. G. Stevens, as Senior Demonstrator of and Joint Lecturer in Biology; Mr. W. C. C. Pakes, reappointed as Demonstrator of Bacteriology; Messrs. J. B. Parfitt and W. R. Wood, as Demonstrators of Practical Dentistry, under the new constitution of the Dental School.

Rumour says that the competitors for the Scholarships numbered 37—a large number, but not the record, which was reached last year with 46.

We would call the attention—not only of Freshmen, but rather and more especially of Senior men—to the remarks, in another column, under the heading, "Surgical Wards," with regard to the inconvenience (and often anxiety) caused to the operator and his dressers by overcrowding into the well of the Operating Theatre and sitting on the back of the lowest seat. There is a general desire for reform and more definite regulations in these matters when the new theatre is built.

This may be our last opportunity of making more widely known the special course of instruction which Mr. Howse is conducting for those men who are "up for" Surgery at the College next month. Mr. Howse takes the intending candidates round his wards on Wednesdays and Saturdays, and after each visit questions them in the Museum for half-an-hour on pathological specimens.

Several important alterations have been made since last Session in the Rules of the Dissecting-room, and in order to draw the attention to them of all men who have not yet finished their work in that department, we have in this number reproduced them at length—as published in a small red-cover book, obtainable from the Medical School Office.

We are asked to note that the Autumn course of Fever Instruction begins on October 8th, at Homerton and Stockwell, and continues on Tuesdays and Fridays during the Session.

Dr. J. H. Bryant has accepted the post of Junior Secretary to the Physical Society in the place of Dr. Campbell.

The first Annual Entertainment of the St. Saviour's Swimming Club is to be held on Tuesday evening, the 8th of October, at 7.30, at their headquarters, the St. Saviour's Swimming Baths, which—as we before remarked—are largely used by Guy's men. Some of our best swimmers will assist, and it is only right to hope that more may be amongst the competitors for the open events, as we should especially like to see the "Wigan" Cup—four lengths' (134 yards) handicap—adorning the Students' Club walls. This cup, presented by the generosity of Sir Frederick Wigan, becomes the absolute property of the winner each year.

Calendar of Coming Events.

October 1st.—Winter Session begins.
House Dinner 6 p.m.
First Meeting of Physical Society at 8.
Paper by Mr. G. De'Ath at 8.
First Conjoint Examination begins.
Examination for D.P.H. Cambridge begins.
„ 3rd.—Second Conjoint Examination begins.
„ 5th.—1st XV. v. Rosslyn Park at Acton.
Association trial games—1st and 2nd XI's at Honor Oak Park.
„ 8th.—Dental Society at 4.30. Paper on "Artificial Crowns" by A. G. G. Plumley.
„ 9th.—Third Conjoint begins.
„ 10th—Certificates of Registration sent in by this date.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various Constituent Institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the Clubs and Societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription, or of a composition fee (see Clubs' Union Blue Book p. 14), to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the Constituent Institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situate close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the London, Chatham and Dover Railway. It is nine acres in extent and is the head-quarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several Clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

The ground-man, who is a professional cricketer, has quarters in the pavilion. His duties are to keep the ground in order, to prepare the wickets and lawn tennis courts, and to bowl to such members of the Union as shall be selected by the committee of the Cricket Club. Lockers may be rented on application to the ground-man, at a charge of 5s. for the summer or winter season.

Cheap Railway tickets between London Bridge and Honor Oak Park Stations are issued to members of the Union upon conditions which will be found enumerated in the Clubs' Union Blue Book.

THE HOSPITAL "BLUE."—The "Blue" is awarded by the "Blues" committee to members of the five following teams:—Rugby Football, Association Football, Cricket, Lawn Tennis, Athletics, after considering the list of men suggested by the various clubs' committees through their delegates.

"Blues" are awarded so that at the end of each season the Rugby Football team be represented by fifteen "Blues," the Association Football by eleven, the Cricket by eleven, the Lawn Tennis by three, and the Athletic team by a number dependent on the suggestions of the committee of the Athletic Club: (for instance, if the Rugby team at the end of the season contains ten players, who have already earned their "Blue" in the football team, the "Blues" committee will award five new "Blues," so as to make the number up to fifteen).

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUB.—President: J. N. C. Davies-Colley, M.A., M.C., F.R.C.S. Rugby—Captain: K. B. Alexander. Hon. Secretary: W. Tyson. Captain Second XV.: T. Morgan, and a committee of five, one representing each year. Association—Captain: R. T. Fitz-Hugh. Hon. Secretary: H. Bernard-Onraët. Captain Second XI.: R. W. B. Hall, and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season of 1894–5 being the fifty-first. Very little is known about its early history; it is, however, recorded that when the Rugby Union was formed in 1871, the G.H.F.C. was one of the original pioneers, and the only Hospital Club in the movement; it then had a reputation second to none. The Club's position in the Football world was acknowledged by the Union electing J. H. Ewart to serve on its first committee, which included such historic names as A. Rutter (president), E. H. Ash (hon. secretary), F. J. Currey, F. Stokes, and A. G. Guillemard. Amongst the many brilliant players who at one time or another have appeared for Guy's, may be mentioned the following International Footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain, 1877–8), A. S. Taylor, W. G. Mitchell and A. Allport (England); H. M. Jordan (Wales); R. Evans (Scotland); and F. O. Stoker (Ireland).

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's were fortunate enough to secure for the first time. Since its institution, St. Thomas's have held the Cup eight times; Guy's four times—the last occasion being in 1886; St. George's three times; London and St. Bartholomew's twice each; and Middlesex once.

In 1891, Guy's, Middlesex, and St. Thomas's were left in, the ties not being played out.

The prospects of the ensuing season are already being warmly discussed in the smoking-room, and elsewhere, and the well-worn subject of our chances of winning the Cup this year occupies a prominent place, as usual. Three of last season's team will not be eligible to play—Hancock, Bell and Dudgeon—whose places it will be no easy task to fill. The usual number of Internationals, "Blues," and other minor football lights are said to be coming up; but if a very small percentage of these rumours turn out correct, the team of 1895–96 should be well able to satisfactorily go through the long list of fixtures.

At present our weakness would seem likely to be behind the scrimmage; however, much can be accomplished by combination, and we must depend on this rather than on individual brilliancy. The forwards ought to be a good lot, as seven of last year's pack will be available.

We hope that backs as well as forwards will make the best use of the very excellent opportunities there are at Honor Oak Park and in the Gymnasium of getting fit and keeping so.

We shall combine with St. Thomas's Hospital against Blackheath, Cardiff and Newport; the last named being substituted for Swansea. Several new fixtures have been arranged, including London Scottish, Harlequins, Royal Engineers, R.M.A. (Woolwich), and London Welsh, whilst matches will be played against Cambridge University, Coventry and Leicester.

It has been decided to run a Third Team this year, under the captaincy of A. J. Cleveland. Several matches have been arranged, and it is hoped that this new departure will prove a success.

A trial game will be held on October 2nd or 3rd, further notice of which will be posted on the notice-boards. All freshmen wishing to take part in Hospital Football are particularly requested to try and make a point of playing in this game. The first match will be on October 5th, v. Rosslyn Park. A ball for practice can always be obtained at the ground at Honor Oak Park. The officers of the Club will always be very glad to give any information required.

The following matches have been arranged for this season:—

FIRST FIFTEEN.

Oct. 5.	Rosslyn Park	Away.
12.	*Blackheath	Away.
16.	Cambridge	Away.
19.	Leicester	Away.
26.	*Cardiff	Away.
28.	*Newport	Away.
30.	East Sheen...	Away.
Nov. 2.	Lennox	Home.
9.	London Welsh	Home.
13.	R.M.A.	Home.
16.	Wickham Park	Home.
23.	Catford Bridge	Home.
30.	Lennox	Away.
Dec. 4.	East Sheen	Home.
7.	Old Merchant Taylors	Home.
11.	Royal Engineers	Away.
14.	Kensington	Home.
21.	London Scottish	Away.
Jan. 11.	Coventry	Away.
18.	Harlequins	Away.
25.	Rosslyn Park	Home.
Feb. 1.	R.I.E.C.	Away.
8.	Marlboro' Nomads	Home.
15.	Kensington	Away.
22.		
29.	Old Leysians	Home.
Mar. 7.	Richmond	Away.
14.	Old Merchant Taylors	Away.

*Combined with St. Thomas's.

SECOND FIFTEEN.

Oct. 12.	Lennox	Home.
19.	Kensington...	Away.
26.	London and Westminster Bank...	Home.
Nov. 2.	St. Thomas's Hospital	Away.
6.	Merchant Taylors' School ...	Away.
9.		
16.	Beckenham	Away.
23.		
30.	St. Bartholomew's Hospital ...	Home.
Dec. 4.	Saracens	Away.
7.	Sidcup	Away.
14.	Bank of India, Australia & China	Away.
21.		
Jan. 11.	St. Thomas's Hospital	Home.
18.		
25.	Brockley	Away.
Feb. 1.		
8.	Lennox	Away.
15.	Sutton	Home.
22.	Brockley	Home.
29.	Beckenham	Away.
Mar. 7.	London and Westminster Bank...	Away.
14.	Kensington...	Home.
21.	Sidcup	Home.

The Association Football Club was instituted in 1882; the Inter-Hospital Challenge Cup in 1885. For four successive years (1885–9 inclusive) Guy's held the Inter-Hospital "Soccer" Cup, and in addition the Surrey Cup in 1887 and 1889, and the Inter-Hospital again in 1894. St. Bartholomew's won the Cup in 1890, 1891, 1893 and 1895; St. Thomas's in 1892. Though we cannot number any Internationals among Guy's Association players, yet many well-known footballers have from time to time appeared, such as H. J. Holman, E. T. D. Mitchell, H. V. Hickman, H. B. Bolus, A. M. Daniel, N. Lavers, A. B. Carter and N. C. Cooper. The season of 1895–6 promises to be as successful, if not more so, than last, when we had to contend against many misfortunes. The fixture list is an excellent one, including nearly all the leading London amateur clubs, with one or two provincial professional teams. We lose the valuable services of R. B. Stamford, who is out of his year. We shall also have to do without our two brilliant backs (Carter and Lidderdale) for the greater part of the season, as they are still suffering from last year's injuries; and if reports are true, they may not turn out at all this winter. We have not heard as yet of any notable players entering this session, so that there is plenty of room for both freshmen and senior men who have yet to make a name. The positions that are vacant are two backs, one right half-back, and an inside left forward. There will be two trial games on October 2nd and 5th, of which further notices will be posted in the Smoking-room. From these games players will be chosen to represent the Hospital in the opening match on the 12th. We hope that all freshmen who play Association will give in their names, with positions on the field, to the captain, R. T. Fitz-Hugh, or to the secretary, H. Bernard-Onraët, as soon as possible. We should like to urge on members of the team, who are unable to play in any match, the necessity of scratching their names as soon as the list is put up, instead of waiting to the last moment, as it is hard lines on the secretary to have to fly about on Saturday morning to

1896.

Jan. 11.—Clinical Evening.
„ 25.—"Headache: Causes and Treatment." C. T. Anderson.
Feb. 8.—"The Diagnostic Value of the Examination of the Blood." W. Ramsden.
„ 22.—Pathological Evening.
Mar. 7.—"Evolution of Sex." G. E. Richmond, B.Sc.
„ 21.—Treasurer's Prize Essay, "The Functions of the Nerve Cells in the Animal Body."

Members are reminded that in connection with the Society, every year prizes are offered for competition. The Treasurer's Prize of £5 is given annually, and the subject for the ensuing Session is "The Functions of Nerve Cells." The Society Prizes include a prize of books or instruments of the value of £10, for the best paper read before the Society during the session; a prize of the value of £4 to the member who distinguishes himself most in the discussions, and a prize of the value of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 40).

THE GUY'S HOSPITAL GAZETTE is the journal of the Pupils' Physical Society, and is conducted by a committee of publication under the chairmanship of J. H. Targett, M.S. A Student member of the Committee is elected by them to act as sole and responsible Editor during such time as the Committee may please. The publication is a fortnightly one, and this issue only is specially enlarged to 52 pages. The first number was "launched" on October 1st, 1872, and the GAZETTE is thus entering on its twenty-fourth year of existence. It was the first Students' Journal ever published in this country, and, as far as can be ascertained, is the oldest in the world. It ran an uninterrupted course until 1879—the last number appearing in November of that year, and was then suppressed, rather from excess of zeal than from lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication; at present it has attained to the proportion of thirty-two pages. The columns of the GAZETTE are open to contributions from all students, old *and* new, and here we cannot do better than quote from the editorial notice of October 1st, 1872: "We would ask all Guy's men to aid us with every information they may think will be useful to their fellow-students. To the Surgical, Medical, and Clinical clerks we shall look for reports of remarkable cases; to the post-mortem clerks for notes of interesting autopsies, and to the others, each in their several departments, for an account of such facts as they may come across in discharging the duties of their appointments, and may think likely to prove of value to others." To this we would add that reports of the various clubs and institutions now comprised under the "Clubs' Union" are always welcome. For news of matches, then, we must look to the various secretaries, who should make either themselves or some other person qualified to write reports of matches, etc. responsible for assistance to us in this direction.

THE CHRISTIAN UNION (Hon. Secs.: C. T. Anderson, A. W. Ormond and W. E. Plummer) has for its object the furtherance of the Christian life at Guy's Hospital. It is the perpetuation of the meetings instituted here by Drs. Habershon and Golding-Bird over forty years ago. On Tuesdays, at 4.15 p.m., meetings are held for Bible study, the next subject being "The life of St. Paul." On Thursdays, at 4.30 p.m., addresses are given by visitors invited for the occasion. The programme for the coming session will be found below. These meetings are held in the Board-room, by the kind permission of the Treasurer. A room (No. 43) in the College is rented by the members for committee meetings, prayer meetings (daily at 12.45 p.m.), study and social intercourse. A Missionary Society has recently been formed, and promises to be a great success. This is an attempt to unite the interest of the students in the work which is being carried on in foreign lands by medical missionaries, and to increase the knowledge of foreign missionary work among all who are in sympathy with it.

PROGRAMME FOR SESSION, OCT.–DEC., 1895.

Oct. 3rd. A Prayer Meeting.
„ 10th. One of a series of Inter-Hospital Meetings.
„ 17th. THE ANNUAL SERMON in the Chapel. Preacher, Rev. H. C. Moule, Ridley Hall, Cambridge.
„ 24th. An Address by Dr. Pye-Smith.
„ 31st. Rev. T. H. Darlow. Subject, "Heredity."
Nov. 7th. A. H. Tubby, Esq., M.S. Subject, "The Manliness of Christ."
„ 14th. Lieut.-Gen. Brownlow. An Address.
„ 21st. Rev. A. B. Boyd-Carpenter. Subject, "Religion in the Medical Profession."
„ 28th. MISSIONARY MEETING. Speaker, Rev. A. E. Cousins, L.M.S. Chairman, C. J. Symonds, Esq., M.S.
Dec. 5th. Two short Addresses by Members.
„ 12th. An Address by Rev. Stuart Fox.
„ 19th. Rev. Prof. Bevan. Subject, "Pessimism."

THE DEBATING SOCIETY.—President: F. W. Pavy, M.D., LL.D., F.R.S. Vice-Presidents: L. E. Shaw, M.D., L. A. Dunn, M.S., and F. G. Hopkins, M.B., B.Sc. Secretaries and Treasurers: M. Hamblin Smith and R. Howard; and a committee of three senior and three junior students.

The Debating Society is entering on its fourth year of existence, and its second as a constituent of the Clubs' Union. It meets once a month, and debates are held on any subject, whether political, scientific, or of general interest, the expression and discussion of theological views, however, is "absolutely prohibited." At the end of the session, a "Ladies' Night" is held, at which lady friends of members are invited, not only to be present, but to take an active part in the discussion. The first meeting will probably be held on the last Saturday in October, the subject for debate on which evening will

shortly be announced. Members desiring to bring forward a subject for debate, must forward to the Secretary their subject, together with the *signature of a member willing to oppose him.*

THE REPORTS.—Edited by W. H. A. Jacobson, M.A., M.Ch., and E. C. Perry, M.D.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are now published annually and contain contributions upon professional and scientific subjects from the Staff of the Hospital and Medical School. The volume of the present year is the 51st, and Guy's may well be proud of the fact. No other hospital has as yet published more than 31 volumes (St. Bartholomew's, the next on the list, has published 30), and one other society only has published more, viz., the Royal Medical Chirurgical Society, which has reached its 76th volume.

THE STUDENTS' CLUB.—President: P. H. Pye-Smith, M.D., F.R.S. Treasurer: C. J. Symonds, M.S. Hon. Secretary: J. Fawcett, M.D. Hon. Assistant Secretary: H. J. Spon. Committee: W. Hale White, M.D., J. W. Washbourn, M.D., A. D. Fripp, M.S., H. T. Bell, V. E. Collins, M. Hamblin Smith, M. H. Thornely, and the President of the Resident Staff.

A full account of the Students' Club rooms will be found in the Clubs' Union Blue Book, p. 48. We are asked to direct attention to the "smoking concerts" which are held every month under the supervision of the Residents. In answer to our appeal last year, we were glad to see that some of our junior men took an active part in these concerts. We hope for more improvement in this respect during the coming season.

The Residents will soon be thinking, doubtless, of the Christmas Minstrels: it should be remembered that the smoking concerts afford opportunity to those who wish to become one of the "Dis Guysed" to prove their worthiness.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the Winter Session a boxing instructor attends on each Thursday afternoon, and a gymnastic and fencing instructor on each Tuesday afternoon. At the end of the Session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

A new apparatus has been erected for the punching-ball, to satisfy the complaints of various of our boxing fraternity. The Hon. Secretary of the Gymnasium is Noel Davies.

THE DENTAL SOCIETY.—President: W. A. Maggs, L.R.C.P., M.R.C.S., L.D.S.. Vice-Presidents: F. Newland-Pedley, F.R.C.S., L.D.S., J. H. Badcock, L.R.C.P., M.R.C.S., L.D.S., H. L. Pillin, L.D.S. Hon. Treasurer: M. F. Hopson, L.D.S. Hon. Secretary: A. DeMierre, and a Committee of five.

The society was founded in the early part of 1894. Its first session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members.

Meetings are held every month during the Winter session. They are held in the Dental Lecture-room, on the second Tuesday in each month, at 4.30 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening. This year, in all probability, a prize will be given for the best paper read before the society.

The first meeting of the ensuing session will be held on Tuesday, October 8th, at 4.30 p.m., when a paper on "Artificial Crowns" will be read by A. G. G. Plumley.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY	12.	Pulmonary bruits. ? Cause.
	23.	Mitral stenosis. Hypertrophy and dilatation of right ventricle. Ascites.
	26.	Ulcerative endocarditis.
	30, 50.	Mitral stenosis.
	38.	Mitral regurgitation.
PHILIP	1.	Aortic regurgitation.
	6.	Aortic and mitral stenosis and regurgitation.
	7.	Mitral and pulmonary regurgitation.
	9.	Aneurysm of 1st part of aorta. Aortic regurgitation.
	14.	Aortic stenosis and regurgitation.
	22.	Hypertrophied and dilated heart. Alcoholism.
STEPHEN	20.	? Aneurysm of Aorta.
	28.	Mitral regurgitation.
	36.	Aneurysm of 1st part of aorta.

Nervous System.

MARY	14.	Paralysis of right arm and leg. Hysteria.
	15.	Hysterical aphonia.
	16.	Cerebral tumour. Optic neuritis.
	33.	Hydrocephalus.
	35.	Cerebral tumour.
	45.	Chorea. Mitral regurgitation.
	46.	Paralysis of right hypoglossal. Secondary carcinomatous growths.
PHILIP	17.	Paraplegia following influenza.
STEPHEN	6, 30.	Paraplegia. Chronic myelitis.
	9.	? Syringomyelia.

STEPHEN 13. Cerebral tumour. Optic atrophy.
40. Right hemiplegia and aphasia. Syphitis.

Alimentary System and Abdomen.

MARY 4. Perforating gastric ulcer. Laparotomy. Excision of ulcer.
9, 48. Gastric ulcer.
11. Hæmatemesis.
19. Appendicitis. Appendicectomy.
31. Tuberculous periostitis.
PHILIP 10. Stricture of sigmoid.
18. Abdominal tumour. ? Carcinoma of stomach.
STEPHEN 1. Gastric ulcer.
7. Tuberculous peritonitis.
8. Ascites.
26. Carcinoma of colon.
27. Tuberculous peritonitis. Pleurisy.
38. Traumatic pyloric obstruction following HCl swallowing. Gastro jejunostomy.

Typhoid Fever.

MARY 5, 7, 17, 18, 21, 28, 34, 42, 43.
PHILIP 4, 19, 25, 38.
STEPHEN 2, 5, 15, 17, 22, 23, 29.

Genito-Urinary System.

MARY 6. Tuberculous kidney. Nephrectomy.
24. Renal tumour. ? Cause.
27, 37. Chronic interstitial nephritis.
49. Hæmaturia. Renal tumour.
PHILIP 2. 37. Chronic tubal nephritis.
12. Diabetes mellitus.
40. Chronic interstitial nephritis.
STEPHEN 31. Chronic tubal nephritis.

Respiratory System.

MARY 39. Asthma.
PHILIP 3, 4. Pleuritic effusion.
STEPHEN 18, 19. Pleuritic effusion.

Phthisis.

MARY 1, 8.
PHILIP 16, 39.
STEPHEN 11, 35.

Miscellaneous.

MARY 8. Eczema.
10, 22, 41. Acute rheumatism.
13. Epistaxis.
32. Menopause.
PHILIP 11. Pain in back, and caries of spine.
15. Gout.
21. Multiple thrombosis of veins of legs.
26, 32. Acute rheumatism.
29. Lymphadenoma. Mediastinal growth.
STEPHEN 24. Acute rheumatism.
33. Pyrexia. Rigors. ? Cause.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN 14. Stricture. Catheterism.
17. Fissured anus.
19. Fluid tumour of upper jaw. ? Follicular odontome.
CHARITY 6. Recurrent carcinoma mammæ.
16. Recurrent carcinoma mammæ.

CASES UNDER MR. DAVIES-COLLEY.

LYDIA 2. Old injury about elbow-joint, leaving deformity. ? Fracture of ulnar.
4. Old housemaid's knee. Abscess.
5. Recurrent ganglion of palmar bursa and flexor sheaths.
6. Disease of frontal sinus.
9. Carcinoma of rectum. Excised. Recurrence. ? Secondary growths.
LUKE 8. Pain in back and left heel. ? Cause.
20. Left inguinal hernia. Hydrocele. Same side six years ago.

CASES UNDER MR. LUCAS (MR. LANE acting).

LYDIA 12. Chronic effusion both knee-joints. Glands excised from right axilla five weeks ago. Abscess at lower end of fibula, with thickening of bone.
15. Internal derangement of knee (Internal cartilage removed formerly). Loose external cartilage.
JOB 18. Epithelioma of prepuce and frænum glands in both groins. Excised.
25. Old osteotomy of femur (Gowans). Refracture. Wired.
CHARITY 4. Multiple tuberculous lesions.
5. Enlarged glands in neck. ? Lymphadenectasis. ? Tuberculous.

CASES UNDER MR. GOLDING-BIRD.

ACCIDENT 16. Fractured tibia and fibula.
29. Fractured ribs. Emphysema.
31. Fractured base.
CORNELIUS 2. Pott's fracture.
11. Cut eyeball. Enucleation.
16. Fractured ribs. Bronchitis.
MARTHA 6. Strangulated femoral hernia. Kelotomy.
8. Ovarian tumour. Partially cystic.
16. Tumour connected with lower ribs. ? Nature.
17. Multiple tumours of rectus abdominis.
18. Hæmatosis of scalp. Contusion of brain.
19. Fracture into knee-joint. Hæmarthrosis.
Cot. Symptoms of strangulated inguinal hernia. ? Tubercle of tunica vaginalis.
— Tuberculous hip-joint (one year's history).

LAZARUS 6. Malignant pustule. Excised on third day.
8. Perineal abscess.
16. Angina Ludovici. Incised and scraped.
19. Popliteal aneurysm, treated by compression of femoral.
22. Recurrent periostitis of tibia.

CASE UNDER MR. JACOBSON (MR. SYMONDS acting).

NAAMAN 20. Recurrence of melanotic sarcoma of breast and axillary glands. Excised.

CASES UNDER MR. SYMONDS.

LUKE 5. ? Synovial fringe in shoulder-joint.
17. Loose cartilage in left knee.

MARTHA 13. Double hare-lip and cleft palate.

CASES UNDER MR. LANE.

JOB 14. Effusion into both knee-joints. Contraction of elbow-joint. ? Gonorrhœal. ? Rheumatic.

DORCAS 5. Recurrent carcinoma mammæ.

Case A (of the three cases of jaundice reported in the last issue) died on the 12th, and there was an autopsy on the following day. The primary seat of the disease was carcinoma of the common bile duct. The new growth projected slightly into the lumen of the duodenum. There was a duodenal ulcer (non-malignant) in the first part of the duodenum, which had perforated, and was adherent to the under surface of the liver. No secondary nodules of growth were visible in the liver, nor did that organ appear to be much enlarged.

Marriage of Mr. R. C. Lucas.

THE marriage of Mr. R. Clement Lucas, son of the late N. Lucas, Esq., of Oaklands, West Lavington, Sussex, with Miss Kathleen Pelly, younger daughter of the late Surgeon-General Saville Marriott Pelly, C.B., was solemnised in St. Mildred's Parish Church, Lee, Kent, on September 17th. The wedding was a very quiet one, owing to the recent death of the bride's father, whose obituary appeared in the GUY'S HOSPITAL GAZETTE on April 27th last. The bride, who was dressed in a grey silk bengaline, was given away by her elder brother, the Rev. Stanley Pelly, Vicar of Swanwick, Derbyshire, and the ceremony was performed by the Rev. Wilfred Thorold, Rector of Stamby and Gunby, Lincolnshire, an old friend of the bridegroom, whilst Mr. Lionel Thorold acted as best man. Mr. Lucas was supported by his brother, James Lucas, Esq., of Elmleigh, Midhurst, and Captain and Mrs. Saville Herbert Pelly were also present. The ceremony concluded, the guests repaired to Woodstock House, the residence of the bride's mother, after which the happy pair proceeded on their wedding trip to Derbyshire. Mr. Lucas will recommence his duties at the Hospital on October 1st.

Chapel News.

CONTRIBUTED BY THE CHAPLAIN.

A word of welcome to the new-comers must be our first note. It will indeed be gratifying to all concerned if the Chapel prove to be of service to our students, collegians or otherwise. We know of no rule, written or unwritten, which appropriates the place to the use of nurses and patients only. The daily routine of our nursing staff, and of the residents at the Hospital generally, tends, no doubt, to create an impression that the Chapel is set apart chiefly for "a congregation of the female gender," as one of our patients once expressed it. But the impression ought not to exist, except as an impression which is of no practical value. To all who are connected with Guy's and to whom it may be convenient to attend the services, we say: Welcome.

There is a clergyman working in South London who attempts, on the first page of his parish magazine, to give a sketch of the present organisation of the Church of England. At the top of the page stands the name of the Archbishop of the Province, then the name of the Bishop of the Diocese, then the Archdeacon, and so on. In this way it is brought home to his people that their parish is but a part of a greater whole. We have no wish to see this fact lost to view at Guy's. That Dr. Talbot, Vicar of Leeds, will shortly become Bishop of Rochester calls for our prayerful attention in, possibly, two ways. He will be our Bishop and, if the precedent of former years be followed, he will also be a member of our Court of Governors. As late Warden of Keble and as Chaplain of the Leeds Infirmary, he cannot fail to take a deep interest in our Hospital and Medical School.

The Chaplain is anxiously waiting to hear from men who will volunteer to read the lessons on Sundays and to sing in the choir.

It is pleasant to be able to say that the debt on the Reredos Fund is now fully discharged. The Treasurer has most generously come to the rescue, and we tender him our grateful thanks.

Our Harvest Festival always takes place on the first Sunday after Michaelmas Day. The offertories on October 6th will, as usual, be given to Foreign Missions.

During October the Communion Service will be sung to Woodward in A, the Magnificat and Nunc Dimitis to Maunder in C.

Under certain restrictions, the Chapel Organ is available for those who wish to practise. The key is kept at the Chaplain's House, and application should be made to him.

Appointments.

THE following appointments have been made by the Treasurer:—

House-Physicians.—Mr. A. A. H. Partridge (Dr. Hale White); Mr. J. H. Horton (Dr. Pye-Smith).

Assistant House-Physicians.—Messrs. L. E. C. Every-Clayton and A. V. Clarke.

House-Surgeons.—Mr. S. Copley (Mr. Howse); Mr. C. H. Bryant (Mr. Davies Colley); Mr. W. E. Robinson Lucas) (for three months only).

Assistant House-Surgeons.—Messrs. B. A. Richmond and E. T. Shorland.

Obstetric Residents.—Messrs. H. W. Beach (October), A. P. Beddard (November) and E. C. Taylor (December).

Ophthalmic Assistant.—Mr. A. H. Leete.

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. R. H. Hayes, E. E. Henderson, T. B. Poole, H. R. T. Fort, B. B. Ham, M. A. Key.

Dressers in the Eye Wards.—Messrs. E. Fisk, W. E. Hills (Mr. Higgens) (November); G. Gocher, G. B. Muriel (Mr. Brailey) (November).

Surgeons' Dressers.—Messrs. A. H. Spicer, H. Leader, C. P. Weekes, N. Lavers, D. Rice, H. V. Smith (Mr. Howse); A. Earnshaw, M. C. Hayward, C. R. Evans, J. N. Gardiner, A. J. Wernet, W. F. Reckitt (Mr. Davies-Colley); C. H. Fagge, W. Ramsden, A. W. Ormond, C. E. Michael, R. P. Rowlands, E. Ivens Spriggs (Mr. Lucas); E. Moore, E. E. D. Hancock, F. J. Lidderdale, C. T. Anderson, E. C. Hort, S. C. Clapham (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. V. E. Collins, R. Howard, A. R. Adams, R. Kay, F. E. Fremantle (Mr. Jacobson); F. W. Lee, C. H. Mossop, H. Simson, F. H. R. Heath, F. J. H. Martin (Mr. Symonds); J. Moore, A. J. Hull, S. E. Denyer, J. E. Dupigny, R. B. Stamford (Mr. Lane); H. Fulton, H. M. Berncastle, C. L. G. Chapman, R. Fell, C. W. Gibson (Mr. Dunn).

Medical Ward Clerks.—Messrs. C. A. C. Askew, J. M. Fortescue-Brickdale, G. K. Levick, D. L. Smith, W. A. Fuller, J. O. Garland, C. R. Hodgson, E. J. O'Meara, M. H. Thornely, J. B. A. Treusch, M. H. Way, C. C. Worts, W. J. Lindsay, A. E. Porter, W. C. Milward, E. S. Hall, Evan Evans, R. W. Mayston, W. N. East, W. J. S. Harvey, H. J. Starling, A. Kinsey-Morgan, D. B. Todd, J. H. Jones, S. H. Longhurst, G. B. Pearson, W. Mussellwhite, E. G. Goddard, C. C. Poole, S. D. Pennington, H. W. Allan, W. P. Grellet, A. W. Nourse, C. D. Outred, A. H. M. Saward, T. J. Vick.

Assistant Physicians' Clerks.—Messrs. C. A. C. Salmon, A. M. Rygate (Dr. Pitt); R. J. Rowland, R. S. Rowland (Dr. Shaw); J. B. Walters, J. G. Watts (Dr. Washbourn).

Aural Surgeon's Dressers.—Messrs. J. W. Bird, H. Alexander (November—December).

Dental Surgeons' Dressers.—Messrs. C. Hunter (October November); T. M. Thomas (November—December).

Dressers in the Throat Department.—Messrs. J. B. Parfitt, S. G. Graham, J. C. Constable, W. S. Handley, C. J. Harnett, J. A. Howard, H. J. Spon, P. E. Tresidder.

Post-mortem Clerks.—Messrs. A. R. Hitchfield, F. G. Thomas (October—November); N. H. Pike, H. E. Izard (November—December); H. P. Ferraby (December—January).

Obstetric Out-Patients' Clerks.—Messrs. W. E. Robinson, F. A. Godson (first half); J. Howell, R. H. Ashwin, C. D. Edwards (second half).

Surgical Ward Clerks.—Messrs. H. Cardin, L. H. Lewis, S. H. Mason, H. J. Barker, H. W. Bruce, P. W. Moore, G. N. Mottram, H. D. Peile, H. C. Regnart, W. H. M. Telling, V. J. Crawford, A. H. B. Kirkman, J. E. Powell, G. E. Richmond, C. Shepherd, C. B. Thomson, P. Turner, T. H. W. Landon, W. K. Wills, C. E. Hibbard.

Prosectors.—Messrs. E. G. Andrew, J. Atkins, J. E. Bridger, F. W. Brook, C. T. Hilton, J. F. McDougall, G. N. Meachen, D. J. Munro, A. G. G. Plumley, A. C. Ransford, H. M. Reeve, W. B. Secretan, W. G. Stewart, R. H. J. Swan, F. D. Turner.

Dental Appointments.

THE following appointments have been recommended by the Dental Council and approved by the Treasurer:—

Assistant Dental House-Surgeon.—C. J. Hinchliff.

Demonstrators in Conservation Room.—G. Chatterton, E. E. D. Heesom, L. S. Hounsell.

Whiffs from the Smoking Room.

"Since we cannot attain to greatness, let us revenge ourselves by railing at it."—MONTAIGNE.

"At last," said the College Man, "I have done with exams. and can now begin to learn something. I shall now spend more time over clinical work, and less at 'getting up lists,' and learning strings of things. Lucky for me I was not obliged to use a stethoscope at the College."

"Perhaps you think the examiners have not got so far as Laennec's great discovery?" sneered the Clever Man. "I like to hear you people talk and carp at the examiners, when you are only able to get through by the skin of your teeth."

"But surely examinations are exceedingly inadequate tests of a man's attainments," suggested the Oxford Man. "Apart, however, from the weariness they put one to, in learning matter of little relative interest, I think they evoke a very much greater evil. I mean the debasing effect they must have on the examiners."

"I never looked at it in that light before," said the College Man, "but the thought is consoling."

'I call it rather a matter for regret than for consolation," rejoined the Oxford Man; "for surely by this process we see men who might have been excellent remaining mediocre. They set under the process like a joint in plaster, and it requires more than passive movement to restore them to mental sprightliness."

"Nonsense!" replied the Clever Man, "all the best men have been examiners."

"Yes, and by so being have so much sacrificed their original talents. I hold of course," continued the Oxford Man, "that the process affects individuals differently, for, as the surgery books would put it, examiners are congenital and acquired, and the acquired variety is never so obdurate as the congenital, being more amenable to treatment."

"You would reckon Mr. X. of the congenital variety, I suppose," remarked the Clever Man.

"Encysted congenital," corrected the Oxford Man. "Yes, certainly, a good example too; but he has not, like some, lost all humour and other humane attributes in the process, for the simple reason he never possessed these attributes; but from the fact of his nature being pandered to he became encysted ten years ago."

"Yet he is one of the best and fairest examiners," rejoined the Clever Man.

"Exactly my point," said the Oxford Man, "he has gained this faculty at the expense of his originality."

"Do you then deny him all originality?" demanded the Clever Man.

"Not at all, for he has never had the bad taste to write a book. Surely that is positive proof of an original——"

But here the Oxford Man was interrupted by the Lazy Man rising noisily from his chair, upsetting a cup of tea, and yawning loudly.

The conversation was not resumed. BEN.

Nursing News.

LIST of Probationers and Lady Pupils who have passed the Surgical Examination, August, 1895:—

Bell.	Hinkley.	Searle.
Busford.	Jones, C.	Suart.
Britton.	Leir.	Tubbs.
Cooper.	Loveday.	Thain.
Cooke.	Miller.	Traves.
Davidson.	Morrah.	Taylor, E.
Edmonds.	Rye.	Witherington.
Eaton.	Paterson.	Woole.
Hudleston.	Powell.	Weekes.
Harris.	Roff.	Wooldridge.
Hyland.	Salmon.	

It is at last, we hope, quite decided that the "Nurses' Lawn Tennis Club" will hold a Tournament early in October. Some difficulty has been experienced in the final arrangements, owing to the large number of Nurses away for their summer holiday.

First Meeting of the Physical Society.

PROGRAMME.

6 p.m. Dinner in College Hall (admission by ticket).
7 p.m. Smoking and Reading Rooms with Scientific Exhibition opened.
8 p.m. Paper to be read in the Anatomical Theatre by Mr. De'Ath.
9 p.m. Tea and Coffee—in College Hall.

SOME OF THE EXHIBITORS.

1. Down Bros. Surgical Instruments.
2. Stanley. Mounting and Photographic Apparatus.
3. Kanthack. Zeiss Microscopes.
4. Swift. Microscopes and Microtomes.
5. Hewlett's Histology Cabinet.
6. Millikin & Lawley. Osteology.
7. Photographic Committee.
8. Hospital Artist.

ORDER OF PROCEEDINGS AT PHYSICAL.

Presentation of Royal Humane Society's Certificate to Mr. H. C. Regnart.
Secretary to read the minutes.
Dr. Wilks in the Chair.
Paper read by Mr. De'Ath.
Vote of thanks to Reader.
Reader's reply.
Vote of thanks to Treasurer.
Treasurer's reply.
Vote of thanks to Dr. Wilks.
Dr. Wilks' reply.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

E. E. A., TUNBRIDGE WELLS.—The lymphatic gland is extensively infiltrated with squamous-celled epithelioma, and the growth is much degenerated.

R. G. H., Ramsgate.—The specimen shows general induration of the breast tissue with dilatation of some of the ducts. The large cyst has a smooth fibrous wall, and there is no evidence of malignant disease in any part of the mammary gland.

H. H. Du B., Weymouth.—The fragments show the subcutaneous tissues infiltrated with a somewhat dense epitheliomatous growth. There are no cell-nests, and the growth has some of the characters of a rodent ulcer.

G. F. H., Balham.—No tubercle bacilli could be found in the sputum.

G. F. H., Balham.—The examination of the membrane showed a large number of bacilli and cocci, but nothing resembling the bacillus diphtheriæ. The culture shows no growth characteristic of diphtheria, and the microscopic examination confirms this. The majority of the organisms are streptococci.

F. H., New Ferry.—The examination of the membrane revealed various bacilli and cocci, but nothing resembling the bacillus diphtheriæ. On the culture, nothing but cocci—as staphylococci and streptococci—could be found.

J. M. J., Alton.—No tubercle bacilli could be found in the sputum, nor any fragments of new growth, hydatid membrane, etc. It appeared to be composed entirely of pus.

B., Sutton.—The examination of the membrane direct showed a very varied assortment of bacteria, chief among which being a fair-sized thick bacillus, and including other bacilli, sarcinæ, staphylococci and streptococci. The culture showed a pure culture of the first-named bacillus. We wonder what the fluid in the bottle is, as it appears to have had some influence upon the subsequent growth.

J., Leigh.—The membrane showed a number of cocci with a few bacilli not resembling the bacillus diphtheriæ. On the culture there was a growth consisting of small colonies which were found to be streptococci. No bacilli diphtheriæ could be found.

A. D., Wantage.—Tubercle bacilli are present in the sputum in fair numbers.

PATHOLOGIST.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Sir,—Will you kindly give publicity to the following letter, as a warning to other Guy's men who may have received similar letters:—

Care of Mr. Lowe,
High Street, Gt. Ilford, Essex.
August 20th, 1895.

My dear Pendlebury,—I have had some reverses lately, and am staying at this village in Essex to recoup. I have had an attack, with some serious symptoms, of nephritis; but since I have been here I am decidedly better, and the albumin is diminishing in quantity daily, but I am yet weak and much depressed—especially as my money is exhausted—and I am going to trespass on old friendship by asking you to lend me a little for a short time. I shall be in funds soon, and I will gladly remit it to you.

I know that I can rely upon your sympathy. will write to you and explain more fully when I hear from you, which, I hope will, if possible, be by return, meanwhile I am, dear Pendlebury, faithfully yours, DAVID S. LONG.

Dr. J. P. Pendlebury.

Dr. Pendlebury, feeling suspicious, found out my real address, and wrote to me about the matter. The whole story is a fabrication, and we have not been able to discover the perpetrator thereof, though we have made enquiries. We have reason to believe that at least one or two similar letters have been sent to other people.—I am, etc., D. S. LONG.

74, Micklegate, York.

A Marriage Gift to Mr. Lucas.

Dear Sir,—After reading the annotation in the last issue of the Guy's Gazette I had hoped this would have been in time, but I see by to-day's papers the knot is tied and Mr. Lucas is married; yet I hope it is not too late to ask through your medium the co-operation of Mr. Lucas's old dressers to subscribe towards a suitable gift—say a piece of plate—in commemoration of his marriage.—I am, dear Sir, yours faithfully,

JOHN FREDK. BRISCOE.

Alton, Hants, September 20th, 1895.

[By the time these lines are in print, a subscription list, only delayed by the vacation, will be open for both Past and Present Guyites. Mr. A. H. Leete, President of the Residents, will be happy to receive any communications by post, whilst other men have also promised to lend their aid.]

"To the House-Surgeon, Guy's."

(We are enabled to publish a note which sheds fresh light on the public idea of the House-Surgeon's duties and accomplishments. We trust the evident good faith of the letter may be rewarded.)

Palgrave,
Tuesday Morning.

Sir,—I now rite to you hardly knowing how to begin this note as Sir I dont know you and you dont know me but as I was reading your name in the newspaper called the Peoaple last night I thought that you Sir you could if you know you could give me information of what I

want. Sir I dont know if you knew that Lady by the name of Mrs. Hawes who used to live right in front of Guys Hospital and she used to take young Doctors from the Hospital her husband Mr Samuel Hawes died a few years ago then she left London and came down in the Country and lived at a little village called Palgrave and that is where I first saw her and then after a time she moved to a town half a mile away bye the name of Diss she went back to London to live again about 4 weeks ago and when I went and bid her good bye I forgot Sir to ask her for her address only I know she is liveing somewhere near Guys Hospatil she is a stout old lady and where a large bonnot if you please Sir if you know her would you be so kind as to send me her address if you could I should be so much obliged to you for your kindness her name Sir Mrs. Samuel Hawes and that is all I know of her now Sir hopeing youwould not mind it if you know it Sir you will greatly oblige me

Miss F Potter
Lion Rode
Palgrave
Nr Diss
Norfolk.

Artists' Rifle Volunteers.

There will be a few vacancies in G Company of the above Corps on November 1st.

The Corps numbers over 800, and is composed of painters, architects, sculptors, students of the various professions, etc., and is largely recruited from the public schools. The corps is well known in London and the Provinces for smartness and general efficiency, and has for several years carried off first prizes at the Royal Military Tournament in competitions open to the whole volunteer force. The battalion goes out twice during the year, into barracks at Easter, and under canvas for a week in August.

The following sections are open to members:—Cyclist, Transport, Signalling, and Ambulance.

The headquarters comprise a large drill hall, accommodation for regimental school of arms, and clubroom for members. The annual subscription is £1 5s. The minimum service accepted is three years. Uniform, equipment, and ammunition are provided free. The standard of height is 5 feet 7 inches, with a chest measurement of 33 inches. Every recruit has to be nominated by a member and approved by the captain before he takes the oath.

Men wishing to join should communicate with S. Whicher or F. D. Turner, who will be pleased to arrange to meet them, and give them any further particulars they may wish to know.

Letters may be left at the letter-window at the front of the Hospital.

Volunteer Medical Staff Corps.

THERE are a few vacancies in No. 2 Company (Guy's, London and St. Mary's) for men anxious for soldiering in this department. The work of the corps consists of the ordinary company and battalion drill of an infantry battalion, together with the special ambulance duties. The corps offers special advantages to men who do not desire rifle-shooting as a compulsory item of volunteering, though there is a shooting club in connection. Easter and the August bank-holiday week see the corps in camp at Netley and Aldershot, and there is usually a small camp at Whitsuntide.

Further information as to terms of service, etc., can be obtained from

SERGT. DIXON.

Volunteer Mess.

AFTER the unqualified success of last year's mess-dinner, it is probable that another will be held early in the session. With this in view, will every new student who is a member of any volunteer corps, and also any existing Guy's man who has been enrolled since the last dinner, kindly send me his name, rank, and corps? A meeting to discuss arrangements will probably be held shortly.

H. FULHAM-TURNER,
Staff-Sergt., V.M.S.C.

Birth.

ALSTON.—On September 11th, at Ardmore, Isleworth, the residence of her father, the wife of W. Evelyn Alston, B.A., M.B., B.C. Cantab. of a daughter.

Marriages.

WILSON-SMITH—WILKS.—On August 28th, at S. Mary's, Oatlands, by the Rev. J. H. Townsend, Vicar, Thomas Wilson-Smith, M.D., of Oldfield Park, Bath, son of the late Thos. Smith, Esq., of Blackheath, to Alice Maud, second daughter of the late J. J. Wilks, Esq., of Oatlands, Surrey.

HARRIS—HOWE.—On September 11th, at St. John's Church, Monkstown, by the Rev. S. Howe (brother of the bride), assisted by the Rev. H. Hawkins, William James Harris, M.A., M.B., F.R.C.S., of Shaftesbury, Dorset, to Kathleen Emily, eldest daughter of the late Lieut.-Col. Wm. Howe, of Monkstown, Co. Cork.

LUCAS—PELLY.—On September 17th, at St. Mildred's, Lee, Kent, Richard Clement Lucas, M.B., B.S., F.R.C.S., of 50, Wimpole Street, W., and of Oaklands, Midhurst, Sussex, to Kathleen, younger daughter of the late Surgeon-General Saville M. Pelly, C.B.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette,

OCTOBER 12, 1895.

First Meeting of the Physical Society.

Dinner was served in the College Hall at 6 p.m. Dr. Pye-Smith, as President of the Students' Club, occupied the chair, and was supported by the Treasurer of the Hospital, and the following members of the Staff:—Drs. Samuel Wilks, Frederick Taylor, Goodhart, Savage, Newton Pitt, Campbell, Starling and Stevens; Messrs. Davies-Colley, Brailey, Symonds, Dunn, Groves, Targett, Fripp, Hopkins, and G. B. Smith. Among old Guy's men present were J. H. Gibson, Aldershot; W. D. Smallpeice, London; G. H. Metcalfe, Clare; W. A. Phillipps, London; E. Deane, Caversham; G. Steele-Perkins, London; Surg.-Capt. G. T. Rawnsley, A.M.S.; H. E. Counsell, Liss; A. S. Taylor, Surbiton; A. W. Sheen, Cardiff; R. M. H. Randell, Beckenham; Lockhart Stephens, Emsworth; G. De'Ath, Buckingham; W. A. Aikin, London; E. C. Kingsford, Brondesbury; A. Green, Chesterfield; F. G. Swayne, Norwood; F. K. Holman, Hampstead; J. Curling Bates, Norwood; E. Lipscombe, St. Albans; J. C. Roberts, Peckham; H. V. Hickman, Wanstead; R. R. W. Oram, Wandsworth. A large number of present students also attended, and after a most successful dinner, the company adjourned to the Anatomical Theatre, where a packed audience assembled.

The chair was taken by Dr. Samuel Wilks, and before commencing the ordinary business of the meeting an interesting ceremony was gone through: the presentation to Mr. H. C. Regnart, a Guy's student, of a Royal Humane Society Certificate, for bravery shown in saving five lives off Aldeburgh. In making the presentation,

Dr. Pye-Smith said: I have been entrusted with the great honour of presenting to one of our number, and we are proud to claim him as one of ourselves, the Certificate awarded by the Royal Humane Society for courage and self-sacrifice in saving or endeavouring to save life. On this occasion the endeavour was successful. It is but seldom that such an opportunity can fall to any one of us. May we all pray that should it happen we may discharge our duty as well as Mr. Regnart did. This is not quite an occasion without precedent, for I remember in the year when I entered as a first year's man that among my fellow students was a Mr. Phillips, who had just previously to our meeting gained this same award for courage and devotion in saving the life of a fellow-creature when drowning. It was in Guy's Hospital chapel that a great divine, the late Frederick Denison Maurice, once the chaplain here, preached a sermon, which I did not hear (cries of "Shame"). The fault, gentlemen, was one of chronology; I was then at a preparatory school. It was told me by Sir William Gull that he then said, "There are two ways to greatness: sympathy and courage." In our profession we have need of both. May you all have that sympathy which is necessary in dealing with our suffering fellow-creatures, and may you all, if occasion should arise, have the courage to follow Mr. Regnart's example.

The Certificate having been presented amid a demonstration of approval,

Dr. Samuel Wilks, as President of the Physical Society, proceeded to offer a few words of welcome to the new comers. He congratulated them on their choice of a profession which, above all others, could be followed in its varied branches with the most intense interest during the whole of their lives. Like his colleague, Dr. Pavy—whom they found still devoting himself to his study, and at the end of a long career finding material to add to the knowledge of his subject—they would acquire much knowledge in the course of their careers at the Hospital, but one thing they would not learn there, viz., that there were diseases having particular names and particular remedies for them. That was not science, but quackery, and he warned them against the quackery and chicanery which existed on so great a scale. Scientific truth none could withstand, so that it was a sure sign of the worthlessness of a system if it existed for a hundred years without being absorbed into the body of general knowledge. When he entered the medical profession he felt pessimistic at the abuses which abounded, but at the end of a long career he could sincerely tell them to be hopeful, to pursue a straightforward path, and they would sure to be right. But let them remember that, having entered the portals of the profession, they were no longer free men; they

had a duty to the profession, and what was true of the profession was true of the particular institution at which they had entered. They were Guy's men—members of an institution with a glorious past. He and the men of his generation were going off the scene; they had to leave the place in the hands of those to whom he spoke, and they looked to them to keep up the old and great traditions of Guy's Hospital. He called upon Mr. George De'Ath, of Buckingham, to read his paper on

OUR PROFESSION, OUR PATIENTS, OUR PUBLIC, AND OUR PRESS.

Mr. Chairman and Gentlemen.—It may seem to many, but I hope not to all, to be somewhat a waste of time to consider the relationships between the Profession, the Press, and the Public. I would ask you in the first place to beware of appearances in all that concerns us, and especially of the apparent relationship between the public and ourselves, particularly at a time when too many of us while boasting of our power, popularity, and knowledge, leave the diagnosis of every "serious" case to a consultant and its treatment to a trained nurse. Popularity has its dangers, and I well remember being told by the late Dean Stanley, "Popularity is all very well if you can get it and if it comes to you, but you must never run after it." Public support is fascinating but fickle. In times of war, soldiers are the pets of the People (and, however strange it may sound, I include all classes in that term), but in times of peace "Doctors" are the fashionable craze. Society, "forsaking even military men," throws her charms to Great Wealth, Successful Humbug, the Drama, and the Medical Profession. We should warn ourselves against judging by appearances, especially those which are nearly always deceptive.

Let us take a somewhat out-of-the-way instance to show what I mean. It is often said, "He does not know his own mind." Of course not. No one knows his own mind. It is one of life's purest pleasures to make its acquaintance. We know the existence of our minds and we infer the existence of mind in others. Far, far away from actual consciousness there appears to be a laboratory in which the influences of our environment, and the impressions from and in our organisms, are received. Much is there stored, and some is poured out into the mind and oozes therefrom as we think, and speak, and write. It is indeed delightful to find out by thinking, writing, or speaking what is "in our minds." It is a useful habit to acquire, because it cultivates the rarest and best characteristic of a medical man—namely, observation. I submit it is necessary for us to see where we are and to see what we are doing, but how rarely we do see. We look but we do not see. We do not see our work, nor ourselves, nor how others see us. Again, look over a landscape of undulating country, with its varied forms of green, its play of colours lit with the great, grand, golden glory of the sun. What do we see? Is what we are looking at merely the veil that covers a continuous crusade or a continual competition? Is the peace of its intense loveliness a mere film hiding the presence of everlasting war? Is the beauty of Nature only the expression of successful cruelty? Again, turn for a moment and ask yourselves if the apparent calm of Humanity is only what covers but does not really conceal the constant, and may I add cruel, struggle for existence? Is it true nowadays, when every man poses as the friend of all men, that Man's inhumanity to Man makes countless thousands mourn? Now you will ask me, What are you driving at? Simply that we must beware of our relationship to the Public, and see to it that it is a true and honourable position for us to occupy; simply that we should learn not merely to look but to see men and women and all things as they actually are, and not only as they appear to be, for "All things are not what they seem," and No Man and No Thing is what he or it appears to be. So, indeed, and too often the appearance of hypocrisy or of honesty in our lives resembles the appearance of Nature where peace is but war and beauty but hidden ugliness. We do not only require lucidity in our view of the outside world, but lucidity of expression in the use of medical terms. Surely we must learn to see men and their maladies as they are. Who can say that there is a scientific uniformity of meaning in the medical terms which we use, and I think too freely use, to the Public? Or even in that process of labelling symptoms with a name which is the plan by which we cheat ourselves that we are misleading others? Do you expect to find the same illness —if such a thing ever occurs—treated in the same way at different hospitals? Perhaps, however, that is only because one star differs from another star in glory. The expressions of medical science are characterised not by their lucidity, but by their looseness. Let me give you an illustration; think of the inconsistent, unscientific, contradictory, and frequently silly position ascribed to "cold" as a factor in the production of disease. Cold is given by a modern writer as the "predominant partner" in the causation of the following maladies (among others):—Croup and tetanus, acute rheumatism and locomotor ataxia, diabetes and pneumonia, acute nephritis and infantile paralysis. Again, a distinguished London doctor—*magnum atque venerabile and nomen*—writes to me by one post to say that a certain person is suffering from eczema, and that the treatment must be directed "towards its microbic causation," and by the next post advises me to tell my patient to avoid exposing her beautiful face to the sun, as that exposure "may produce an attack." We need not pretend that we do not value public esteem and confidence, but what steps do we take to deserve either, when we hide our ignorance or our knowledge under loose terms? The fashion has not yet died out of labelling as "hysterical" any group of symptoms which are inexplicable on known physiological grounds, and this at a time when we do not know with certainty either the real effect of a poultice on the skin or the functions of the liver. The modern student, especially if recently qualified, regards as "neurotic"

all the symptoms which do not come within the range either of his reason or his remedies. How do too many men treat the conditions which they call "neurotic" or "hypochondriacal," meaningless epithets that are used either with that haughtiness which is a proof of ignorance, or with that pity which is only another form of the same narrow-minded contempt? First of all they deny the existence of the malady, then they say there "is nothing the matter," and when the patient recovers under the treatment of a man who is a physician without being a fool, they then sneer at the successful colleague as a man "who humbugs his patients."

A section of the profession, notwithstanding all its post-prandial sentiment, is jealous of success. Surely it is utter nonsense, because it is absolutely unreasonable and deplorably unscientific, for a person to be ill and well, in the ordinary senses of the terms, or that one (apart from the very definite condition of malingering) can "imagine himself ill." People who are ill, are ill, even if we do not understand the illness, and even if we cannot treat it. Let me give one more instance, because it is one which more obviously affects our relationship to the public and our patients. I refer to our unfortunate habit of separating "functional" from "organic" maladies. Function is the expression of organic change, and functional disorder is inconceivable without organic disturbance and change, and the latter is not the least, but the most important factor, even if unrecognised, in those disturbances of health so stupidly called "only functional." It is more conceivable to think of organic change without functional disturbance than of functional disturbance without organic change. Why is all this? Why do we talk thus to the public, and to our patients, and to ourselves? Why do we rely on appearances and vague terms? Why do we thus lose, or deserve to lose, public confidence? Because in hospital life and training we fail to note the value of seeing life as it is, people as they are, or the true meaning of terms. In hospitals we learn about disease, but in practice we have to treat a person with an illness. Large numbers of "cases" (or diseases occurring in persons) pass under our observation in hospital life, but we only see the diseases, not the persons. Not only that, but both the person and the malady are removed from the conditions which would otherwise act on both. Not only that, but the greater part of our hospital life is spent in studying just those maladies, which, however important as types, are least often seen in general practice. In hospitals we see, or rather look at others treating an illness in a person, but in practice we have ourselves to treat a person with an illness. We rarely see those deviations from what we call health which we have to treat in general practice. We thus do not see before we get into practice our work as it really is, but only as it appears to be. Our teachers, to whom no one is or ought to be more grateful than I am, are men who are what they are because they have been successful in hospital practice, or distinguished for successful industry, and these men pass, and perhaps rightly, from the hospital to Harley Street, but they see little or nothing of ordinary general practice, or the "cases" which we as general practitioners have to treat. They teach hospitalism and practice it. Men who have, therefore, to deal with patients, or the public, that is to say start in practice, are lost to some extent, have no power (because they have not the knowledge which is power) to conduct a case, know not how to treat their patients or their patients' friends, cannot even behave themselves in a sick room; in fact many men only go into a sick room for the first time after they are qualified. We must remember that the proper study for the medical man at all events is Man. A hospital is no more and no less the place to learn the diseases of mankind, so far as the relationship between patients and medical men are concerned, than are the Zoological Gardens the proper place in which to learn or to study the natural habits of animals. Much can be found out at either place, but as at the Zoological Gardens we see animals under unusual or unnatural conditions, so in hospitals we see illnesses and people separated from the conditions by which they are both surrounded when we as medical men have to treat them. These considerations affect the public as a body, and the public individually, or as our patients as we call them. I would speak of the latter first. A patient expects that his medical man should be something more than a mere medicine man; that his doctor should be more than a detective to discover some pathological flaw in his health; something more than an accountant to bring out the balance of a diagnosis from the "complicated accounts" of his symptoms. The public also expect much, and perhaps too much from its public professional men in the protection of "Health." To us, of course, health is only a relative term, but to the public it is an attainable reality. I have never seen a case of health, and I should like to see a really healthy man, woman or child; and it is, by-the-bye, in the detection of the insignificant departures from an indefinite standard that the skill of a "doctor" lies. We do not treat the public fairly in the matter of health. For instance, we say "Disinfect," but there is no reliable standard either of disinfection or a disinfectant. Again, people want to know what to do "in cases of illness," emergencies, and "epidemics." What do we do? What does the profession do? It supplies the public with scientific beef-tea, not in tins but in lectures, it attempts to boil down the hard bones of science to suit the digestion of the public intellect, it floods the press not only with watery but adulterated solutions of science, while essences of surgical treatment and tabloids of medical knowledge are manufactured wholesale for general consumption. We want to appear to know and to make others like unto us. This is what is called and appears as the popularisation of knowledge, but in reality it is the prostitution of science. No doubt a knowledge of the laws of health can be taught (the means by which homes should be kept clean and filth removed from the person and the house, the advantages of light, air, and the diet of children), but amateur

medicine and surgery are less reliable than the professional articles. We think we are to teach our patients and the public what we know. If so, they must learn as we do. If our methods of teaching the public are right, then our own methods of learning are both wrong and useless. We allow the public to think we can dispense clinical therapeutics for them. People demand the knowledge how to treat illness, and we supply "a lecture," or a "course of lectures." I have often, and I do again beg to protest against such "apparent teaching," against the policy of sprinkling the community (by means of a more or less oratorical pepper-box), with tit bits of knowledge, whether pathological, physiological, obstetric, or hygienic. There are no such short cuts to knowledge. The appearance is not the reality, and, as we learn, so we should teach, and not otherwise. A desire to know is admirable, but the public are nowadays too inquisitive about illness. Our national manners show a deplorable lack of taste and good feeling in the presence of illness. If a man consults his lawyer, he does not find all his friends asking him "what is his business," or "why did he seek legal advice?" Let such a man, however, consult his doctor, and at once all his friends and acquaintances, sometimes perhaps out of kindness, but oftener out of curiosity, or in the case of a celebrity out of a feeling of snobbery, at once rush to know what his business was with his doctor, and why he sought medical advice. It is sad to have to add that even the doctor himself is asked "concerning the case," and it is a shameful thing to have to admit that the information is often granted. The near relations of a patient may be told the nature of an illness, but without the express sanction of the patient or his closest relations no medical man has any right to make any sort of communication to anyone else, not even, I submit, to the medical press. The so-called upper classes, or certain sections, have, let us not forget, brought advertisement to an art. It is time we did something to protect the privacy of the home, especially of the sick room. To publish clinical details or to throw the sop of a temperature chart to the gossiping wolves, to make a sick room a market for advertising, are practices which are too disgusting and far too common. We all know the twaddle which is talked in the profession about advertising, especially by the sort of man who, swearing he would never advertise, advertised. Our medical press bids fair to become the mouthpiece of the would-be successful traders and of the professional Pecksniffs and Chadbands. For instance, the contribution of cases is intended to advance knowledge, not to puff practitioners. We must look up to our press, but it should represent all that is most dignified and all that is best. Look at the view which is taken by the medical press (and, of course, I am only speaking of some papers) on any subject of general interest, such as vaccination. The coarsest, the rudest, the most insulting language, is considered too good for those who, though supported by men of science and undoubted honour, feel a conscientious objection to compulsory vaccination. Dictation is not dignity, and the policy of kicking your opponents to death should hardly be the characteristic of the wonderful and advanced medical knowledge of the nineteenth century. We must bear in mind that the lay press is ever struggling to get personal details. It is, I submit, a national calamity to see the honour, purity, and responsibility of the press stained, and even in some instances washed away by the muddy waters of competition. The necessity for paragraphs begets inaccuracy, and belief in the papers is becoming a sure sign of credulity. It is sad, indeed, to see the reckless manner in which that pompous person, "our own correspondent," not only endangers the peace of nations by his highly-coloured and self-imagined crises, but violates the privacy of home life by the publication of details of illness, which are generally inaccurate and always inexcusable. We, as a profession, must not worship the golden calf of the "Press" too much. From what I see and hear in London, not only the press but the profession is giving way before the rising and surging waves of competition. I may point out that although some say competition creates commerce, yet others say it curses it. Must we, however, use such an argument? We must, I fear, if it is true that men who ought to know better and who occupy "high positions," are not ashamed to steal other men's patients, or to be consultants at one part of the day, physicians another, surgeons another, specialists another, general practitioners another, while all the day long they violate those rules of professional honour to which they do homage only with their lips and not with their lives. These are the men who undermine confidence, with "all the kind mendacity of hints," or with a silence more suggestive than speech. When people ask for "another opinion," what they want, oftentimes, is a "different opinion," and they very often get it, for how many men allow themselves to be privately interviewed by "friends" and receive fees for such interviews when the conversation turns on "the recent consultation?" These are the men who undermine our press and our patients and force so many of the public to look upon us as money-grubbing humbugs; these are the men who "get practices" by a "swagger turn out," by grand looking houses startlingly painted, by large parties, by gorgeously dressed wives, or by pandering to the bare-faced snobbery of modern society. We must not imitate the methods by which sycophants succeed. We should value public confidence, but we should also deserve it; we should wish for respect, but we should not get it under false pretences. All the world is filled with loud praises as to "the advancements" in the prevention and treatment of suffering, but novelties are not necessarily improvements, as revolutions are not always reforms or reforms always revolutions. The light which competition in the press throws into the privacy of the home also finds its way into the laboratory, and the discovery of yesterday is trumpeted as the mark of an epoch. We are thus apt to follow fashions and fads rather than facts. I well remember, only about ten years ago, when I had the great privilege of being a student at Guy's (and

I think every medical man should be a medical student all his life), that the profession was suffering from a very acute attack of the "spray." I know one distinguished surgeon who was almost "cut" by his colleagues for not using it. How different now! The profession is now suffering from convulsive attacks of bacteriology. When I left Guy's the spray ruled surgery, now we all worship germs. In the interests of truth, we should appreciate, and not exaggerate, the relative value of all parts of science. I will only simply allude to "the importance of serum therapeutics," or the policy of quieting the pathological Paul by extracts from the immunised Peter. Every problem is discussed in the press, and owing to the habit of pseudo-philosophical generalisation from insignificant details which now characterises modern journalism, the public and our patients are misled. In these days, when the fierce light of publicity beats around a test-tube, we must not so quickly take the public into our confidence, especially in the press. Our duty is to look for the truth, not to encourage competition. Our patients are led to think they know so much, and, therefore, when an illness arises they now make the diagnosis, and decide on the treatment and the proper specialist to consult. The first question a lady asks, when she hears her servant has got rheumatic fever is, "Can she take salicylate?" We know very little, but the public know less. People now have one medical man for every organ, and I know a lady who consults one man for her eyes, another for her throat, another for her "chest," another for her menstrual troubles, and she herself decides "what is wrong," and then asks me to reconcile the contradictory pieces of advice which she gets from "her London doctors." The false relationships of our public and our press and our patients to our profession are our own fault. Let us think less of our successes and more of our failures, less of the possible glory of the future and more of the darkness of the present, less of our "modern advances" and more of our modern helplessness, less of the possibilities of science and more of its simplest theories. Are the foundations of our knowledge sure? Do we know, for certain, the functions of any organ of the body? Are we adding to or lessening human misery and woe? Is our science a tower of Babel? I believe we shall do best if we do right, and we shall do right if we recollect every hour of our professional lives not merely our "advanced knowledge," but our appalling and lamentable ignorance. I want to show that we should not fix our eyes only on the advancing waves, especially as waves have a knack of receding, that we should not be led away by our apparent popularity and power; but that we should simply do what is right, and not ostentatiously act as if we knew so much more than we do. Our knowledge is vast, but our ignorance is more vast. It is easier to explain away a symptom on the principles of a sort of four o'clock tea kind of physiology, than to treat the condition to which the symptom may be a guide. As a profession, we must not puff nor be puffed up. We are getting too proud. The ruling monarch of the world, namely, Ignorance, has ever had dogmatism and cocksuredness as his equerries-in-waiting permanently on duty. We rush like a lot of sheep at every new therapeutic fad, and sneer at the wary and wiser public for their indifference. Science loses nothing and gains much when it combines with sense, and the medical man does not know less of disease if he knows something of human nature. Those who have to treat people who are "ill" should study those who are "well." We should value character more than a certificate, and a real success more than an apparent victory. We should be as men treating other men, not as hospitalised beings treating patients. In all our relationships we should remember that kindness, gentleness, and sympathy add to the true value of skill, and that though the powers of the head are great, the powers of the heart are greater. We can do much by our abilities but more by our affections, and although we now have "to live in wearied hope," yet it is not the possible only but the perfect we should live for, ever bearing in mind that "greatness is to take the small things of life and walk grandly among them."

Mr. W. C. Pakes:—I have to propose a hearty vote of thanks to Mr. De'Ath for his splendid paper. It seems almost superfluous for me to do so, after the magnificent ovation he has already received, but I am sure I am only expressing the feelings of everyone present when I say that a more brilliant and witty address, nor one containing more sound sense, has seldom demanded our attention in this theatre.

The vote was carried with acclamation, and acknowledged.

Mr. L. A. Parry proposed, and Mr. E. Ivens Spriggs seconded, a vote of thanks to the Treasurer for his presence and the practical interest he had consistently shown in the welfare and success of the students.

The Treasurer, in acknowledging the vote, said: I could almost wish that I had to return thanks every day for the great help the Staff and all connected with Guy's Hospital render to me. Without their assistance and guidance the Treasurer would have a poor chance of succeeding. On this occasion I should like to have the opportunity of a few remarks, which I trust will be deserving of your notice. I have not said a word yet of the great loss we have all suffered in the death of Mr. Durham. His loss is one that we shall never forget. I cannot help rejoicing that all those who are connected with this Hospital so liberally and promptly responded to the proposal that two beds should be endowed in his memory. The cost of these beds will be £2,000, and I am happy to say that the whole of that money has been found. One bed will be placed in each of the wards, Lazarus and Martha, with which he was associated for so many years, and before long I hope you will see a suitable sign placed in each ward saying that the bed has been founded in memory of Arthur Durham. I feel it is owing to the unanimity of sentiment which exists among all Guy's people that within the course of a few months

we have been able to realise this large sum. I have to hope, gentlemen, that you will each and all do your utmost to aid and assist us in realising such sufficient subscriptions from the public as will enable us to carry on this great institution with its full number of beds. Without the assistance of Guy's men I should despair of doing this, but I feel sure, when I think of the great influence they exercise in various parts of the country, that your assistance will go far to enable us to maintain this place in full service and efficiency. I will not say more now, because I know your hearts are with me, and that your desires and efforts will be on my side.

Mr. Lockhart Stephens: Mr. Chairman, a very pleasant task has been allotted to me, inasmuch as I have been asked to offer you, sir, our sincere thanks for coming down to-night and once more presiding at the opening meeting. You have, yourself, in your address, supplied the explanation of that extraordinary affection which exists in the hearts of Guy's men towards yourself—it lies in that innate power and strength which you possess of going absolutely straight. The Treasurer has alluded to the present state of the Hospital finances. Some two months ago now, a report of Guy's Hospital reached me, and on reading it through one could not but be gratified at the economy displayed in the management of this Institution, and the thought crossed my mind that if anyone ought to do anything for the Hospital, old Guy's men ought to. As my own banker's balance at the moment was not in a flourishing condition, I thought the thing to do was to put the authorities on the track of those who had large balances, so I wrote out a list of thirty rich patients and sent their names and addresses to the Secretary to the Treasurer. Some days after I saw some of these reports on the tables of several patients. One lady asked me if I knew anything about it, Well, I said, I do, and I hope you will read it through and, if needed, I can vouch for its contents. Whatever I have been able to do for you you owe to that Hospital; and, I said, don't forget that. I took that as a text—the lady is still digesting it, and I have not the slightest fear that before long the products of digestion will reach the Hospital. I met some old Guy's men to-day, and it seemed to me we ought not to lose this opportunity of doing what we could for the Hospital. I am quite aware it is a cruel thing to flog a willing horse, but I think it would not be a very great act of self-denial that every Guy's man should do something. There are two thousand of them at least scattered about London and the provinces, and half of them should be able to give a guinea each per annum. There is an income of a £1,000 a year at once, besides all the influence they can exert in other directions. Wishing at the same time to give additional weight to the suggestion, some of us have approached Dr. Wilks, and asked him to take the chairmanship of an old Guy's Committee for the raising of assistance for the Hospital; and if he is at our head, out of pure love and affection for him, many a man will give who would not otherwise think about it. In a few minutes, before dinner this evening, some twenty-five old representative Guy's men consented to join the proposed committee, and through such a combination I am sure a very substantial tribute to the finances of the Hospital will be forthcoming. I beg to propose a most hearty vote of thanks to you, sir, for presiding this evening, and we all trust you may still be spared many years to come here.

Mr. Every-Clayton: To me has been appointed the enjoyable task of supporting the vote of thanks to Dr. Wilks which has just been proposed by Mr. Lockhart Stephens. We all know how at the opening and closing meeting of the Physical Society Dr. Wilks comes amongst us to welcome the fresh man and stimulate the chronic. On each occasion we, as is most fitting, return him our warmest thanks. But I would remind you there is much more than this for which we thank Dr. Wilks. We have to thank him for what he has been; for what he is; for pointing the way along which we, as Guy's men, if worthy disciples of our great teachers, should walk. Among the honoured names of Guy's, among those whose reputations will spread the fame of this Hospital and School throughout all lands, among those who, full of years and full of honours, will send their footsteps echoing down the corridors of time, not the last nor least is Dr. Wilks. But I would further remind you that in showing such gratitude to those who have done so much for us, we must not lose sight of the great Institution which lies behind—the Hospital and School, without which we could not come into any sort of relation with them—without which we (as medical students) and the general public could not know those priceless benefits which accrue from the continued existence in an active state of a great teaching hospital and school. This, then, seems a fitting time and place in which to call the attention of all Guy's men who are here to-night, and through them the attention of numerous absentees, to a parallel scheme to that introduced by Mr. Lockhart Stephens which is already on foot for the co-operation of all present students of Guy's in the maintenance of the financial position of the Hospital. It is very encouraging to note the success which has attended the appeal for the fund known as the Arthur Durham Memorial. For it is there demonstrated how much can be done when the students make an effort. You would see in last Saturday's Gazette that one student alone was responsible for no less a sum than fifty pounds. I feel satisfied that yet more substantial benefit will arise when the students bond themselves together for this purpose. Time only allows of brief mention of the ways in which they can help. One's friends are often anxious to support some sort of charity, but in these days of advertisement and charlatanism they are doubtful what way to take. The student may, then, safely guide the hand which draws the cheque. Or, again, people outside in an influential position are desirous of obtaining the best medical and surgical treatment for their dependents, be it tenant, servant, or the poor in the parish. A subscription of one guinea to the Hospital ensures three letters of recommendation. And so there are numerous

other ways, which will transpire later, of doing lasting benefit to our old Alma Mater, and of preventing her—with her great name and traditions—from going forth a beggar to the world. Gentlemen, I have heartfelt pleasure in seconding a vote of thanks to him, who above all in the sweetness and purity of his private character and the commanding eminence of his position in the medical world, is evermore an example of what a Guy's man may be and should be. I refer, of course, to Dr. Wilks.

Dr. Wilks having replied, the meeting terminated.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary 1. Chlorosis.
2. Aortic stenosis and regurgitation. Mitral regurgitation.
12. Pulmonary bruits. ? Cause.
14, 25, 37, 49. Mitral regurgitation.
32, Aortic and mitral stenosis and regurgitation.
33. Hydrocephalus. ? Cerebellar tumour.
40. Aortic aneurysm. Aortic regurgitation.
50. Mitral stenosis and regurgitation. Tricuspid regurgitation.

Philip 8. Aortic regurgitation.
39. Aortic aneurysm. Well marked tracheal tugging.

Stephen 14. Aortic and mitral regurgitation. Enlarged liver. Hydrothorax.
19. Aortic, mitral, tricuspid regurgitation. Pleuritic effusion.
23. Leucocythæmia. Enlarged spleen.
33. Ulcerative endocarditis.
36. Aortic aneurysm. Optic atrophy. Jacksonian epilepsy.

Nervous System.

Mary 3. Optic neuritis. ? Cause.
8. Exophthalmic goître.
16. Cerebral tumour.
30. Cerebellar tumour.
37. Chorea. Mitral regurgitation.
46. Right hypoglossal paralysis. Secondary carcinomatous nodules in cranium.

Philip 6. Headache: vertigo.
17. Paraplegia. Chronic myelitis.
28. Sciatica.
33. Cerebral syphilis. Ptosis, deafness, &c.

Stephen 1. Locomotor ataxy.
5, 40. Right hemiplegia and aphasia.
6. Paraplegia. Chronic myelitis.
13. Cerebral tumour. Optic atrophy.
24. Optic neuritis. ? Cause.

Alimentary System.

Mary 21, 48. Gastric ulcer.
26. Carcinoma of liver. Primary carcinoma of stomach.
29. Anorexia nervosa.
45. Ascites. Tuberculous peritonitis. Phthisis. Lardaceous liver.

Philip 14. Hæmatemesis. Gastric ulcer.
24. Jaundice. ? Cause. Abdominal tumour. ? Cause.

Stephen 7. Ascites. Tuberculous peritonitis.
8. Ascites.
26. ? Carcinoma of cæcum.
27. Tuberculous peritonitis.

Typhoid Fever.

Mary 17, 18, 21, 31, 42, 43.
Philip 2, 5, 19, 25, 37, 38.
Stephen 2, 29.

Genito-Urinary System.

Mary 6. Tuberculous kidney. Nephrectomy.
23. Granular kidney. Hypertrophied and dilated heart.
47. Diabetes mellitus.

Philip 12. Diabetes mellitus.
18. Tubal nephritis.
36, 40. Chronic tubal nephritis.

Stephen 4. Diabetes mellitus.
31. Chronic tubal nephritis.
32. Chronic interstitial nephritis.

Respiratory System.

Mary 39. Asthma.
41. Fœtid expectoration. ? Empyema opening into lung. ? Gangrene.

Philip 1. Pleuritic effusion. 14th aspiration.
27. Left pleuritic effusion.
29. Mediastinal growth. Primary lymphadenoma of intestine.
34. Hæmoptysis.

Stephen 18. Pleuritic effusion.

Phthisis.

Mary 4, 38.
Philip 20, 31.
Stephen 12, 35, 39.

Miscellaneous.

Mary 28. Gonorrhœal rheumatism.

Philip 3. Gonorrhœal rheumatism.
15. Congenital syphilis. Enlarged spleen.
30. Chronic plumbism.

Stephen 38. ? Addison's disease.

Case under Dr. Goodhart.

Sarcoma of Bronchial Glands—Pressure on the Right Bronchus—Pneumonia—Pleuritic Effusion—Secondary Growth in the Lungs—Renal Calculi—Chronic Tubal Nephritis—Chronic Endocarditis—Mitral Regurgitation.

Philip 3.—M., æt. 36, a carman. Admitted September 11th for dyspnœa and pain in the front of the chest. Married; has four healthy children. He has always enjoyed good health; he has been in the army, and served in South Africa. In 1879 he suffered from acute rheumatism. Three weeks ago he had a bad cough and brought up phlegm, and sweated a good deal at night; for the last fortnight has had pain in his chest, as if a heavy weight was there. He has lost flesh lately. He was sent up from the Out-patients, where a diagnosis of right pneumothorax was suggested, on account of the very bad entry of air all over the right side of the chest.

Condition on admission.—Temperature 101·4°; pulse 92; respiration 28. Strong, well-built man, 5 ft. 6½ in. in height; weight, 11 stone 5 lb. No œdema of legs.

Respiratory system.—Barrel-shaped chest, wide epigastric angle, movements equal on the two sides. T.V.F. better marked at the left apex than the right. The percussion note on the right side of the chest not so good on the right as on the left. Very deficient entry of air all over the right side, back and front. Sputum abundant and frothy; no tubercle bacilli found.

Heart normal. Nothing abnormal felt in the abdomen. *Urine* neutral, 1016. Albumin 2 parts per 1000.

September 12th. The difference in the percussion note still more marked. Very deficient entry of air over right side of chest.

14th. Dulness over right side, behind. Pleuritic effusion right base diagnosed.

17th. Diarrhœa; blood in the motions.

20th. Right base explored and a small quantity of serous fluid withdrawn.

26th. Pleuritic rub heard at right base in front.

October 2nd. Œdema below sixth rib on the right side behind; absence of entry of air over dull area; absent voice sounds. Marked œdema of the back. Chronic nephritis diagnosed.

6th. At 11.55 p.m. patient had a severe attack of dyspnœa. Right side of chest aspirated and 86 ounces of clear serous fluid withdrawn. Breathing was very much relieved. About an hour later he had another severe attack of dyspnœa, to which he succumbed.

Autopsy.—Fourteen hours after death. A large mass of soft sarcomatous glands were found surrounding, invading, and stenosing the right bronchus. The whole of the right lung was solid. There was a large secondary growth, about two inches in diameter, in the inner third of the right upper lobe. The rest of this lobe was in a state of breaking-down pneumonia. The middle and lower lobes were solid from broncho-pneumonia and deposits of secondary growth, many of which latter had the appearance of tubercle.

The heart weighed 9½ ounces. The mitral valve was considerably thickened, its circumference measured 4½ inches, and the chordæ tendineæ were thickened. The spleen weighed 16½ ounces and was very hard; on section, it had a lardaceous appearance, but showed no lardaceous reaction when Tincture of Iodine was applied.

Both kidneys were very large, and together weighed 30 ounces. These were both in a condition of advanced chronic tubal nephritis. In addition, the left kidney contained two very large irregular brownish-yellow uric acid calculi, and also a large number of smaller calculi, some rounded, some facetted.

One of the most striking features of this case was the absence of œdema of the legs, associated with such marked chronic tubal nephritis. It was only during the last week that much œdema was noticed, and that was confined to the back. He gave no history of pain in the loin or colic; there was no hæmaturia; in fact, nothing pointing to the pressure of renal calculi. This, however, may be explained by the fact that the calculi were firmly fixed and moulded to the pelvis and dilated calyces, so that jolting movements would not alter their position.

In the Surgical Wards.

Cases under Mr. Davies-Colley.

Cornelius	4.	Comminuted fracture of femur from direct injury.
Lydia	1.	Involution cysts in breast. Amputation of breast. Breast indurated with numerous cysts in it.
	4.	Old ununited fracture of upper end of tibia.
	7.	Scirrhus in axilla; starting apparently in outlying lobule of breast. Removal of mass.
	17.	Tumour of back resembling clinically a chronic abscess; on removal found to be a vascular tumour. ? Nævus.
	18.	Strangulated femoral hernia.
	21.	Old amputation of thigh; neuromata in stump.
Luke	9.	Enlarged prostate. Retention. Suprapubic puncture.
	11.	Hæmorrhoids.
	12.	Enlarged prostate.

Cases under Mr. Lucas.

Job	4.	Hydrocele of tunica vaginalis.
	5.	Symptoms pointing to stone in the bladder.
	23.	Old fractured tibia. Prominence of one of the fragments.
Charity	8.	Chronic arthritis of hip and knee joints after acute rheumatism.
	23.	Spinal caries. Old necrosis of femur. Abscess in thigh.
Lydia	11.	Recurrent spindle-celled sarcoma of breast.

Case under Mr. Golding-Bird.

Lazarus 14. Loose internal semi-lunar cartilage of knee.

Case under Mr. Symonds.

Job 10. Stricture of urethra. Numerous perineal fistulæ. Previous external urethrotomy. *Suppurating glands in groin.*

Case under Mr. Lane.

Job 15. Vesical calculus. Lithotrity.

Case under Mr. Dunn.

Lazarus 3. Urethritis. Frequency of micturition, hæmaturia, etc. ? Prostatitis and cystitis.

In the "Charity."

TWO DIFFICULT LABOURS.

I. Decapitation.

A patient, Mrs. M. B., has had three children, all at full time and straightforward. Patient was last unwell on March 25th. There is no history of any injury or fright of late, although six weeks ago she was very frightened by a bedstead falling on her little girl. Has been suffering from bronchitis for the last week. She first saw a slight "show" on Friday, September 20th, and since then she has been losing on and off. Pains commenced on Sunday morning, September 22nd, but were not sharp until Monday evening, the 23rd, at 9 o'clock, when patient sent up her "card" to the Hospital. She rested a good deal that day, but did not keep her bed.

Patient did not know when the membranes ruptured, and up to the time when the pains became sharp she did not think that anything was going wrong, and expected to go on to full term.

The Charities went down about 10.45 p.m., and found patient was on the bed, looking very pale and worn out. Pulse 132.

On abdominal examination, the fœtus was thought to be lying in a transverse position, L.D.P., but the head could not be felt in either iliac fossa.

On vaginal examination, the left hand was presenting at the vulva. It looked decomposed and smelt decidedly foul. Chloroform was administered. The os uteri was found rigid, and only sufficiently dilated to admit two fingers, and under difficulties version was persevered with for nearly two hours, but as patient's condition was getting worse, it was decided to send for Dr. Galabin. About ten minutes after the anæsthetic had been discontinued, patient had some severe spasms, and became perfectly rigid with opisthotonos; pulse was 158 per minute; respirations almost stopped. Hypodermic injections of brandy and inhalation of Amyl Nitrite restored patient after some little time.

Dr. Galabin arrived at 2 a.m., and chloroform was again administered. Dr. Galabin tried first to perform version, but soon found it impossible, and as in all probability the child was dead, decapitation was decided on. The presenting arm was pulled on, so as to bring the neck over the os uteri, but, however, the fœtus would not move. This caused increased difficulty, because the serrated hook had to be passed far into the uterus, and great difficulty was experienced in guarding its point. After delivery of the body, the after-coming head was very troublesome to remove. Dr. Galabin tried to extract it with the long curved forceps, but could not get sufficient hold. Next, the face was made to present over the os, and traction with a finger in the mouth was made, but proved unsuccessful. Perforation was then performed, and the head extracted with craniotomy forceps.

After delivery of the placenta, the uterus was washed out with 1 in 3000 Lotio Hyd. Perchlor., and at 4.30 a.m. the patient was left. Pulse 100.

September 24th. 11 a.m.: uterus again washed out 1 in 3000 Lotio Hyd. Perchlor.; temperature 98°; pulse 98; cough troublesome; ordered Mist. Oxymel Co. 6.30 p.m.: temperature 98°; pulse 100; vagina syringed with 1 in 3000 Hyd. Perch.; discharge not foul, and only slightly coloured.

25th. 11 a.m.: temperature 98·4°; pulse 92; vagina syringed; Iodoform puffed into vagina. 7 p.m.: temperature 98·6°; pulse 84; syringed.

26th. 11 a.m.: temperature 98·6°; pulse 92; syringed. 7 p.m.: temperature 99·2°; pulse 88; syringed. Patient feels much better; no pain in the uterus or abdomen.

27th. Temperature 99·2°; pulse 88.

Patient during the next few days had a severe attack of bronchitis, but now she is practically convalescent.

The above report is by Nurse O'Donnell, of the Guy's Institution, who also acted as extern to this case.

The above presents some interesting points in the fact that from the history of the case, the short time that the pains had been on, and the patient getting about up to a few hours before we were sent for, seemed to make it probable that the hand and arm could not have been in the vagina long; and, as the arm was discoloured and a little macerated, it was thought most probable that the fœtus was also macerated. However, on delivery of the fœtus it was found that only the prolapsed arm and hand were macerated; the rest of the body being normal. So there seems no doubt that the membranes must have ruptured some time back, and that the arm was in the vagina for some days.

Dr. Galabin tried version, but could not reach a knee or a foot. This is interesting and worthy of record, for in the whole of his experience this was the first case in which he found it impossible.

Dr. Galabin, in his Manual of Midwifery (page 471), says, "It is only in very rare and long neglected cases that version will fail in moderately skilful hands, if chloroform be given to the full surgical degree, and if the small blunt hook or noose be employed if required, to make traction upon the knee or foot. *I have never met*

with a case in which a knee or foot could not be reached." The serrated hook, also, is stated by some authorities to so often fail to cut through the neck; in this case it was perfectly accomplished under more than ordinary difficulties in a very short space of time.

II. Perforation—Cephalotripsy.

It may be remembered that in 1893, Dr. Galabin performed symphysiotomy on a patient in Dorcas with a contracted pelvis. The child was delivered alive, and is still living. There were rumours that the patient's walking powers were impaired by the operation; the real facts of the case were that she entered an infirmary because of a mammary abscess, and not for lameness.

The patient's history, from an obstetric point of view, is a curious one. Her first child was born in March, 1892; she was attended from the Guy's Charity, and Dr. Horrocks delivered by performing embryotomy. In June, 1893, Dr. Galabin delivered by symphysiotomy, and the patient was told that in the event of her becoming pregnant again, it would be well for her to have premature labour induced. This advice she disregarded, and went through her third pregnancy until full term was reached without seeking any advice. As soon as labour pains came on she sent up her card and an Extern went down. On examination, the diagonal conjugate was exactly three inches, but, as Dr. Galabin pointed out, the previous symphysiotomy might have rendered the height of the symphysis a more variable quantity than usual. She was with great difficulty persuaded to come into the Hospital, as she had a firm belief that this time she would "manage all right at home." After admission the pains subsided for some days.

On their return, Dr. Galabin was communicated with, and, the os being dilated by a good bag of membranes, he decided to deliver. The choice between Cæsarian section and cephalotripsy had been previously put before the patient. Considering the degree of contraction of the pelvis, the risks between the two methods were almost equal, but as the patient was in no way anxious for a living child, cephalotripsy was decided on. This was accordingly performed. On rupture of the membranes, the head was felt to be in the L.O.A. position, and a perforation was made through the anterior parietal bone (the right). The brain, after being stirred up by the perforator and the crotchet, was washed out by a stream of boracic lotion from a Higginson's syringe, and the cephalotribe was applied. The blades at first tended to slip off the head of the fœtus laterally towards the mother's sacrum, but on being readjusted a more central hold was obtained. However, the resistance to delivery was such that when powerful traction was made the instrument slipped off the head twice.

Dr. Galabin then passed his hand up and adjusted the blades so that one included the chin and the other reached to the nape of the neck. The head was then delivered in an attitude of extreme flexion, the body following without much difficulty. The jagged orifice made by the perforator was guarded by being placed between the blades of the cephalotribe. The placenta was adherent and was removed by the hand; the uterus was subsequently irrigated with a 1 in 3000 Hydrarg. Perchlor. hot douche.

The patient has made an uninterrupted recovery.

M. A. K.
H. W. C.

Nursing News.

NURSING STAFF CHORAL SOCIETY.

For some time we have been looking forward to what is now an accomplished fact, viz., the formation of a Choral Society for the Nursing Staff under a good conductor.

A meeting was held on Tuesday, October 1st, attended by Mrs. Shaw, Mrs. Perry, the Matron, and a good number of Sisters and Nurses, at which the Officers of the Choral Society were elected, and regulations passed.

The Choral Society will be governed by a President, Treasurer and Secretary, who with one Sister and two Staff Nurses will form a committee.

The committee will be entrusted with the funds of the Society and have power to make any regulations from time to time found necessary.

The Society will be composed of members and honorary members. The members will pay 2s. 6d., and the honorary members 5s. for the season.

Practices will be held every week, on Fridays, at 7.45 p.m., in the drawing-room at the Home.

The members of the Society are to be congratulated on having obtained the kind consent of Mrs. Pye-Smith to act as President, and Mrs. Shaw as Treasurer. Miss F. Nott-Bower is appointed Secretary; Sister Lydia, Nurse Hodges and Nurse Weymouth were elected as members of the committee.

We hope to be able to give a full list of our honorary members and members in the next issue. The first practice was held on Friday, October 11th.

Dental Appointments.

Dressers in the Gas Room.—Messrs. E. Coltman, G. G. Ellis, E. W. Smith, E. W. West.

Dressers in the Ordinary Extraction Room.—Messrs. E. C. Brown, K. W. Goodby, C. H. Knowles, G. A. Pedley.

Guy's Hospital Rifle Association.

A Special General Meeting of the Rifle Association will be held on Wednesday, October 23rd, further particulars of which will be posted in the colonnade.

Passim.

As will be seen in another column, the Arthur Durham Memorial Fund is complete, and henceforward the wards and our memories will be enriched by two Arthur Durham Beds. We heartily congratulate all concerned upon such a splendid success; the simple result of the spontaneous offerings of Guy's men.

The first ordinary meeting of the Physical Society will take place to-night in the Smoking Room at 8 o'clock, when Mr. L. E. V. Every-Clayton will take the chair, and Mr. R. Howard will read his paper on "Life and Death."

The proceedings on the 2nd instant were quite up to the high level of recent years. The audience was in excellent humour, and Mr. De'Ath's sparkling paper was very much indeed to their liking. No one could have delivered that address like Mr. De'Ath himself, and he has to be heard to be fully appreciated. Nevertheless it will prove most entertaining reading for those who were not present.

Mr. H. A. Munro, as President of the Residents, is arranging the first "Smoker" for Saturday, November 2nd, and would be glad to hear at an early date from those men willing to assist in any way.

Messrs. H. A. Munro and W. E. Robinson are now willing to receive the subscriptions from well-wishers of Mr. R. C. Lucas and his bride. We wish them every success.

Dr. J. H. Bryant has been appointed Lecturer to the Nursing Staff, in place of Dr. H. J. Campbell.

"The enthusiasm of Guy's men," we heard remarked the other day, "is very much like the enthusiasm of Englishmen. Where is it when there is no war on?" Quiescent it is true, but when fighting has to be done it is there. We are very hopeful, therefore, that the particulars regarding the Sustentation Fund, which appear on another page, will command ready attention, and that the effort which raised the Durham Fund will be prolonged into the more arduous struggle of placing the Hospital resources out of danger. If Governors, Staff, Students (past and present), Sisters, Lady Pupils and Nurses will but do something, individually and collectively, in this cause, we shall have travelled a long way towards the desired end. The support of all present Guy's men is specially asked towards this fund, and the Temporary Committee are already considering proposals for "raising the wind." Among these are a Dramatic Entertainment and Concert by Guy's men, or a Provincial or Suburban Tour of the "Disguysed"—the latter should, if practicable, prove a regular gold mine.

One of the most distinguished members of the medical profession died on the 1st instant. Sir Thomas Longmore, C.B., passed away at Swanage, after a short illness. Few at Guy's will recollect him now, as he was in his seventy-ninth year at the time of his death, but his was a long career of useful work in the public service and, as he studied at Guy's Hospital before he entered the Navy, we shall endeavour to devote a portion of our space in the next Gazette to a notice of his life and the many honours conferred upon him.

The Debating Society have determined to open their Session's work with the question of "Local Option," for on Saturday next, October 19th, Mr. F. E. Fremantle will uphold that "This house views with favour the rejection of Local Veto at the recent General Election." Strong opposition has already been guaranteed.

We congratulate our swimmers on the good account they gave of themselves at the annual Entertainment of the St. Saviour's Swimming Club. No one passed Mr. W. R. Wood in the Four Lengths Race for the Wigan Cup, and he came in fourth to three of the limit men. His diving display was much appreciated. The Polo team played a drawn Exhibition Match with the Old Askeans, while several of our men performed favourably in the other open event.

We have received a letter proposing that a Chess Club be established at Guy's. The writer, who possibly thinking his initials were sufficiently well known as to render the insertion of his whole name pleonastic, has only this error to thank for its exclusion. He suggests that many men play "this noble and ancient" game, and this being our belief, we shall be pleased to be the means of further correspondence on the matter.

We understand that, probably through ignorance, men using the Club lavatories at Honor Oak Park have failed to comply with the rule which demands the payment of one penny for a bath-towel when obtained from the groundman. We trust it is the last we shall hear of this, and hope by giving this rule greater publicity to aid in preventing its infringement.

Pass List.

University of Durham, September, 1895.

The following gentlemen were recommended for the Degree of Doctor in Medicine for Practitioners of fifteen years' standing:—

Duke, Benjamin, M.R.C.S., L.S.A.
Duke, Edgar, M.R.C.S., L.S.A.
Turner, W. Pickett, M.R.C.S., L.S.A.

Examination for the Degree of Doctor in Medicine.

Eyre, J. W. H., M.B., B.S.

Third Examination for the Degree of Bachelor in Medicine.

Beven, O. (obtained First Class Honours).
Rowland, W. J.

Examination for the Degree of Bachelor in Surgery.

Beven, O.

Second Examination for the Degree of Bachelor in Medicine.

Regnart, H. C.

Calendar of Coming Events.

Oct. 12.—1st XV. (combined with St. Thomas's), v. Blackheath, at the Rectory Field.
2nd XV. v. Lennox, at Honor Oak Park.
1st XI. v. Weybridge, at Weybridge.
2nd XI. v. Old Cranleighans.
Physical Society Meeting, at 8 p.m.
„ 16.—1st XV. v. Cambridge, at Cambridge.
„ 17.—Christian Union Meeting, at 4.30. Sermon by the Rev. H. C. G. Moule.
„ 19.—1st XV. v. Leicester, at Leicester.
2nd XV. v. Kensington, at Wormwood Scrubbs.
3rd XV. v. Streatham III., at Honor Oak Park.
1st XI. v. Old Wilsonians, at Honor Oak Park.
2nd XI. v. Old Wilsonians II.
First Meeting of Debating Society, at 7.30.
„ 23.—General Meeting of Rifle Association.

The Arthur Durham Memorial.

The following is the final list of subscriptions:—

	£	s.	d.
Corrected amount previously acknowledged	1,766	19	6
Burt, Boulton & Haywood, Messrs., Cannon Street, E.C.	10	10	0
D. F.	10	10	0
E. D. A. N.	10	10	0
Anonymous	10	0	0
Aikin, W. A., Esq., M.D., 14, Sumner Place, S.W.	3	3	0
Hood, Donald, Esq., Green Street, W.	2	2	0
Baker, A. E., Esq., 22, Grosvenor Street	1	1	0
Walton, R., Esq., 9, Dorset Square, N.W.	1	1	0
Cuff, H. E., Esq., M.D., Ashtead	1	1	0
Ball, J. A., Esq., M.D., Bromsgrove	1	1	0
Collins, H. W., Esq., Wrington	1	1	0
Cruickshank, J. D., Esq., Chingford	1	1	0
Davies, F., Esq., New North Road, N.	1	1	0
Pillin, H. L., Esq., 33, George Street, W.	1	1	0
Lee, Mary, Miss, Brixton Hill	1	0	0
Thomas, J. D., Esq., M.B., Guy's	0	10	6
Per Miss Hickson—			
Williamson, Mrs., High Pitfold, Haslemere	2	2	0
Allen, Miss, South Australia	1	0	0
Per F. J. Steward, Esq.—			
Spon, H. J., Esq.	1	1	0
Per C. E. Carpmael, Esq.—			
Edwards, C. D., Esq.	0	5	0
Tilbury-Brown, R. T., Esq.	0	2	6
Copley, S., Esq.	0	5	0
Leader, H., Esq.	0	2	6
Stamford, R. B., Esq.	0	5	0
Per Dr. F. Penfold, Rainham—			
Penfold, J., Esq.	1	1	0
Penfold, Mrs.	0	5	0
Cobb, Rev. C. and Mrs.	0	10	0
Wakeley, Mrs. W.	0	5	0
Ludgater, Mrs. and Miss	0	10	0
Boorman, Mrs.	0	5	0
Knight, W., Mrs.	0	5	0
Finnes, Mrs.	0	5	0
Dodd, Misses	0	10	0
Stedman, Mr.	0	5	0
Longley, E., Mr.	0	5	0
Longley, Jno., Mr.	0	5	0
Jelly, Mr.	0	5	0
Wrayman, Mr.	0	5	0
Croft, Mr.	0	5	0
Roberts, Mr.	0	5	0
	£1,834	7	0

From anonymous sources a sufficient sum has been forthcoming to bring the above total up to the sum asked for, £2,000, and to defray the expenses of collection and the cost of the mezzotint portrait. The £2,000 will now be separately invested, and the proceeds paid over to the Hospital for the perpetual maintenance of two Arthur Durham Beds.

The fund is, therefore, now closed, but any subscriptions arriving after this date will, subject to the pleasure of the donors, be placed to the credit of the general funds of the Hospital.

De Examinationibus.

AMONGST THE KROORGINS OF KUNJUNGA.

Some Extracts from a Letter from our Special Correspondent in Darkest Africa.

THERE is, of course, a University in the chief town of Kunjunga, but, naturally, it is not held to be of much account for the education and qualification of Medicine Men. It is not necessary to make any further remarks upon the high state of civilization to which these quaint people have attained; nevertheless, a few notes upon some of their methods of examination may be of interest to you. It so happened that an examination for the "Medicine Faculty" was in progress when I arrived, and one of the Chiefs kindly allowed me to avail myself of the opportunity of being present at this function. Having passed into a roomy mud hut, the portals of which are jealously guarded by men called Kmishnas, belonging to a section of the army, I found myself in the presence of about a dozen sapient old black fellows, elaborately dressed in nothing, squatting on the ground behind roughly hewn logs of wood, which served as tables. The Chief who accompanied me made my introduction to all through my interpreter. Lest my memory should fail me, I produced a note-book and pencil, but hastily replaced it in my pocket after a whispered warning from my cicerone that though I might be simply ejected if seen taking notes of the occurrences, it was more probable that my journey towards the exterior would be "inside" one or more of the Ksamnas, as the members of the examining body are called. It seems that the Kunjunga generally are very sensitive to the criticisms of their public press, and thus they endeavour to forego the irritation that might be caused by the perpetuation of anything curious that might come to pass. The candidates are penned into a small kraal abutting on the back of the examination hut. The most striking thing about them on first sight was that they were an extremely thin and scraggy lot. Enquiry elucidated this point—a good plump candidate is usually speedily devoured. As the flesh of those that use tobacco tastes ill to the cultivated palate of the cannibal gourmet, it did not surprise me, after this, to learn that "no smoking" is an absolute rule for the candidates.

Upon the tables lay a number of curious, irregularly-shaped articles—some black and dried, others painted with varied colours, others, again, bleached white—most of them stuck through with painted bits of reed, or acacia thorns; one or two were contained in ordinary glass jars, such as we see in European museums, but if they had once contained spirits of wine, it had either evaporated or been drunk apparently long since. Pathology was the order of the day, and these were the specimens. I asked whether they did not make use of the rich supply of fresh material that even my short visit had been long enough to show was varied and very extensive. The President of the Ksamnas replied that there was indeed plenty, but that it was never used for examination purposes for several reasons. First, that whilst fresh, the specimens were more familiar in taste than in appearance. Secondly, that in their climate such things would not keep fresh many hours. I had begun to ask why they did not use So-and-So's (much advertised) disinfectant, when my cicerone whispered a second warning. It seems that advertising is most strictly prohibited; in fact, even the most exalted medicine men only allow themselves to advertise themselves when they marry, or contrast their methods with those of others. Anyone transgressing this advertising law is very simply dealt with—he is eaten. But the President continued that, thirdly, they had a good stock of preserved material, such as lay on the table, all carefully catalogued, and always handy; and lastly, that there was a general concurrence of opinion amongst them that the appearances in the fresh state were of comparatively little value. With such cogent arguments it was impossible to disagree. At this point my interpreter suddenly remembered he had to see a man about some dog or another, and my experiences of the examinations in Kunjunga were cut short, for it would have been ill-advised to have parted from my guardian and linguistic angel. Δ.

The Sustentation Fund.

THE Secretary to the Treasurer has supplied us with the following particulars regarding the suggestions for co-operation amongst old Guy's men and present students made by Mr. Lockhart Stephens and Mr. Every-Clayton at the first meeting of the Physical Society.

So far as the authorities are concerned, there is no desire to put pressure on old Guy's men to subscribe personally. Their voluntary subscriptions will, of course, be welcomed, and it is hoped that they will heartily work for the Hospital in the other ways mentioned below. The following are among the methods by which help could be rendered:—

1. By personally subscribing.
2. By influencing patients or friends to subscribe.
3. By taking a collecting-card, or box, or placing one or more of either with suitable persons.
4. By organising entertainments, the proceeds to go to the funds of the Hospital.
5. By obtaining Friendly Society grants, especially in districts where no cottage hospital exists.

As was announced, Dr. Samuel Wilks, F.R.S., consented to act as chairman of a committee, which it is hoped will embrace all past students, and the first names received were those of the following gentlemen:—

Aikin, W. A., M.D., Sumner Place, S.W.
Briscoe, J. F., Alton, Hants.
Counsell, H. E., F.R.C.S., Liss.
Deane, E., Caversham, Reading.
De'Ath, G. H., Buckingham.
Gibson, J. H., Aldershot.
Green, A., M.B., Chesterfield.

Jones, G. M., Alton.
Kingsford, E. C., Brondesbury.
Metcalfe, G. H., Clare, Suffolk.
Muspratt, C. D., M.D., Bournemouth.
Phillipps, W. A., M.D., John Street, Mayfair.
Randell, R. M. H., M.D., Beckenham.
Rawnsley, G. T., A.M.S.
Sheen, A. W., M.D., Cardiff.
Smallpiece, W. G., Queen Anne's Gate, W.
Steele-Perkins, G., M.B., Weymouth Street, W.
Stephens, Lockhart, Emsworth.
Swayne, F. G., M.B., Upper Norwood.
Taylor, A. S., M.D., Kingston-on-Thames.
Thorpe, W. G., M.D., Clapham.

The names of all other old Guy's men willing to join this committee will be received with appreciation. It would, of course, be physically impossible for such a committee to take upon itself executive functions; all that is asked is that individual members should co-operate with headquarters.

Reports, collecting-boxes or cards, or any information required will be immediately provided on application to Mr. C. H. Wells, Secretary to the Treasurer, Guy's Hospital, S.E.

Similarly it is hoped that all present students will join the Students' Committee, which can, perhaps, best work on similar lines to suggestions Nos. 2, 3 and 4 above. The names of students willing to join this committee will be received by Mr. J. A. Reaside, at the Office of the Secretary to the Treasurer. He will be ready to issue cards or collecting boxes, supply information, receive suggestions, and generally to co-operate with students in any measures they may undertake.

The following gentlemen have already sent in their names:—

Anderson, C. T.	Hardenberg, E. F. H.
*Bryant, C. H.	Hicks, R.
*Carpmael, C. E.	Howard, R.
Collier, H. W.	Michael, C. E.
Collins, V. E.	*Munro, H. A.
Edwards, C. D.	Nicholson, T. M.
*Every-Clayton, L. E. V.	Peters, A. E.
*Fagge, C. H.	*Robinson, W. E.
Fitz-Hugh, R.	*Spon, H. J.
Fremantle, F. E.	Spriggs, C. Ivens.
*Hamblin-Smith, M.	Shorland, E. T.
Hancock, W. I.	*Wood, W. R.

Those gentlemen whose names are marked with an asterisk have formed themselves into a temporary Executive Committee. A preliminary meeting has been called for Wednesday next, at 4.30, in the Charities' Room.

There are also the best indications that the Sisters, Lady Pupils and Nurses will lend their aid, and it is needless to add that assistance from them will be heartily welcomed. The Matron has kindly consented to receive any offers of help, and collecting cards and boxes may be obtained from her or direct from the Secretary to the Treasurer.

Guy's Hospital Students' Club.

Statement of Receipts and Expenditure from 1st September, 1894, to August 31st, 1895.

1894 RECEIPTS.

	£	s.	d.
September 1st.			
To Petty Cash Balance in hand	0	6	6
1895			
August 31st.			
To Cash received, per Clubs' Union account, Grant 1893-94	75	0	0
" " per Clubs' Union account, Rent	139	10	0
" " per Clubs' Union account, Grant 1894-95	170	0	0
" " on Library account ...	18	16	2
" " per Hon. Secretary Pavy Gymnasium, Surplus ...	7	1	0
" " Sale of Wine, Beer and Tobacco	462	17	3
	£873	10	11

1894 EXPENDITURE.

	£	s.	d.	£	s.	d.
September 1st						
By Balance due to Bankers ...				57	13	0
1895						
August 31st						
By Cash paid, Furnishing a/c ...				6	10	6
" " Newspapers, Magazines, &c. ...	42	19	8			
" " Printing & Stationery	3	7	6			
" " Sundry Disbts. ...	26	17	8			
				73	4	10
" " On Gymnasium a/c—						
*Hon. Secretary	28	0	0			
Cl'ning&L'ghtng	9	15	0			
				37	15	0
" " Deposit on Bath-room key ...				0	5	0
" " On Library a/c—						
Mudie's Sub. ...	5	5	0			
Librarian ...	12	0	0			
Deposits R'trned	10	10	0			
Note Book ...	0	5	0			
				28	0	0
" " Rent account ...	109	5	6			
" " do. do. ...	30	4	6			
				139	10	0
" " General Repairs ...				7	11	10
" " Cost of Wines, &c.	239	6	0			
" " Stewards'Allow'nce	223	11	3			
				462	17	3
" " Insurance ...				0	12	0
" Balance at Bankers	55	13	3			
" Petty Cash, Balance in hand	3	18	3			
				59	11	6
				£873	10	11

* Balance in hands of Hon. Secretary, £10 16s. 6d. due to Treasurer of Guy's Hospital Students' Club.

Audited and found correct on behalf of the Students' Club. FRED. G. HOPKINS.
October 8th, 1895.

Audited and found correct on behalf of the Clubs' Union. E. IVENS SPRIGGS.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Spastic Paraplegia with Anæmia.

Dear Sir,—Dr. Gowers has favoured me with some very interesting remarks on the pathology of the case of spastic paraplegia lately reported in the Gazette, and with his permission I send you extracts from them. The case naturally thereby gains very much in interest and instructiveness. Dr. Gowers writes:—

"The case is one of very great interest. It belongs to a region of pathology of which we are only beginning to obtain a glimpse. I have lately been observing several cases in which central nervous symptoms were associated with anæmia, and in some cases, lessened with it. You may have noted the important paper Dr. Taylor read last session before the Medical and Chirurgical Society, on the curious association of tabes with pernicious anæmia, an association which had before been noted.

"It is, of course, of great importance to ascertain the precise character of the anæmia, a task which, as you suggest, is seldom within the capacity of the general practitioner . . . . Have you read the chapter on multiple neuritis in the last edition of my manual? If you compare with it the chapter on "lateral sclerosis" you will perceive that it is probable that many toxic agents, instead of acting on the extremity of the nerve fibre in the limbs, act on the extremity of the nerve fibre in the cord, which descend in the pyramidal tracts from the brain. Indeed, the primary degeneration of the lateral columns seems to begin in these extremities and to ascend, and there is strong reason to believe that some toxic agents, such as that of lathyrism, act on these extremities, and that the affection is one of what I have called the upper segment of the motor path, similar to that which in the lower segment is called degenerative multiple neuritis.

"It is impossible to conceive that there can be a grave defect in blood-formation without considerable alteration in the chemical processes and substances formed. Martin's researches on diphtheria show how readily albuminoses in the spleen may be changed, in formation, to toxic agents acting on the nervous system. If you put these things together, does not your case become—if not more clear—a little less obscure."

No doubt there will be some among your readers who, like myself, have read the chapters in Dr. Gowers book without grasping them sufficiently to see the pathology of the case as clearly as Dr. Gowers has put it.—Yours truly, SYDNEY W. MacILWAINE.

Why Men are not keen on Playing Football for the Hospital.

Dear Sir,—On seeing the Rugby XV. for Saturday, October 5th, posted up in the colonnade, I was surprised at the number of new men who were down to play. Surely it would have been better if the committee had given one or two new men a trial, and then if they were short, to pick some men from the regular players of the 2nd XV. What combination is there amongst the new men down to play? It seems to me that if a man comes straight to Guy's from his university or school, he is at once given a trial in the 1st XV. whether he has played for the 1st XV. of his college or not. Several cases can be pointed out where freshmen have played for the 1st XV. for the first few matches of the season, and then have not been chosen to play for either the 1st team or 2nd for the remainder of the season.

Such mistakes about playing new men tend to show that the committee know either absolutely nothing about football, or else they do not care whether they win the first few matches or lose them. If the committee would only use a little more common sense and keep their eyes open, they would soon see who are worthy of their place in the 1st XV.—Yours truly, "FAIR PLAY."

Reviews.

Diseases of the Joints and Spine. By Howard Marsh, F.R.C.S., Surgeon to, and Lecturer on Surgery at St. Bartholomew's Hospital; Consulting Surgeon to the Hospital for Sick Children, Great Ormond Street. (Cassell & Co.) Price 12s. 6d.

A new edition of this excellent manual is very welcome. The present volume has been thoroughly revised, and has been brought well up to date. The author writes clearly and fully upon the subject from the stores of a wide and varied experience, accumulated during many years. As is only natural, the majority of his illustrative cases are drawn from the hospitol with which he is especially connected, and this ensures them being cases which have come under the author's own observation. The book is to be warmly recommended to all students as a most valuable and reliable text-book upon one of the most important branches of surgery. To refer to one section as an example of the rest, we would advise everyone to read Mr. Marsh's account of the articular changes met with in Syringomyelia.

Analytical Key to the Natural Order of Flowering Plants. By Franz Thonner. (Sonnenschein.) Price 2s.

This little volume, which chiefly deals with exotic plants, will form a valuable guide to all who are interested in Botany, and are anxious to refer the various exotic plants they come across to their natural orders. The descriptions are clear, and to the point, and hence are easy to understand and follow. We think the author is very wise in attempting, as far as possible, to classify plants from the appearance presented by the flowers alone, for nothing is more annoying to the searcher after truth than to have a full description of the characters of the fruit and seeds, which he cannot see, at the time that he is examining and seeking to classify a flower, whilst the parts which he can see are either hardly referred to at all, or are at most but briefly described.

The Dental Society.

An ordinary meeting—the first of the session—of the Society was held on Tuesday, October 8th, 1895, at 4.30 p.m. Mr. Maggs, the President, in the chair. The minutes of the last meeting were read and confirmed.

On casual communications being called for—

Mr. Goadby showed a case of gemination of a temporary lateral and canine.

Mr. Cook brought forward a model showing supernumerary canine and malformed lateral.

Mr. Jacobs presented to the Society a number of old forceps and other instruments.

Mr. Bascombe presented a model showing a supernumerary tooth erupted between the permanent upper centrals.

The Chairman then read his Presidential Address:—Permit me to thank you for the honour you have conferred upon me in electing me President. The success of this Society during the first year of its existence is a proof of the advantages of a Dental Students' Society. Bacon said, "Reading makes the full man, writing the exact man, and speech the ready man." We all have ample opportunities of reading and writing, which opportunities we utilize more or less profitably; but it is not often we can indulge in extemporaneous speech. It should be the ambition of every man to become a good public speaker. The first requisite is to know your subject, and the next to be able to put it before your hearers in a concise and lucid manner. Many a novice comes to grief from lack of confidence, and this can only be gained by previous preparation and practice. There is a story told of an old Scotch minister, who was asked how long he would require to prepare a speech, and who replied, "If I am to speak for 15 minutes I should like a week to think of it; if I can have half an hour I can do it in three days; but if I can go on as long as I like I am ready now!" The moral is obvious—that previous study is required in order to say all that is necessary without being prosy or verbose. Some men are naturally diffident, and are reluctant to express their views, however competent they may be. This Society affords the capable, unreliant men opportunities of discussing technical matters before a friendly, albeit a critical audience. Readers of papers sometimes display not only oratorical talent, but intimate acquaintance with some subject, gained perhaps from exceptional experience, which specific information may not be known even to the author until he puts his facts into writing. It has been said that anyone can read a paper, but the real difficulty lies in replying to the discussion thereon. If I may say a word of criticism concerning the scope of the papers read during last session, it is that perhaps some of them were too discursive. I should prefer the consideration of debatable scientific points, or methods of practice, with a view, if possible, of formulating or deducing some common ground of assent, or dissent. Gentlemen, I hope you will all help to contribute to the success of the Society during the ensuing session by reading papers, bringing forward casual communications, microscopic specimens, and by joining in the discussions. In conclusion, I am glad to say your energetic honorary secretary informs me that several interesting papers have been promised.

The Chairman then called on Mr. A. G. G. Plumley for his paper on

ARTIFICIAL CROWNS.

Mr. President and Gentlemen,—On being asked by our secretary to read a Paper before this Society, now entering on the second year of its existence, the idea occurred to me that one on Artificial Crowns would present many interesting features. The importance of the subject—being one of the foremost methods employed by us in the conservative treatment of roots, bringing them to a state of efficiency and usefulness, contrasting favourably with their fellows—appeals to every student, whose future success depends, more now than it has in the past, on the skill he can acquire in producing a valuable and artistic substitute to a crownless root. Some judgment must be exercised in selecting a root which will keep healthy under its new conditions; it should not be loose, exostosed, or surrounded by unhealthy gum; and before actual crowning the success of the root-filling should be assured, as in case of failure it is exceedingly difficult and painful to take off a well-fitting crown once firmly fixed. In spite of this, however, it has been asserted by some that a tooth which has been the seat of chronic abscess will, on being crowned, become healthy again, even when the roots will not yield to treatment. Crowns may be divided into porcelain and metal, both of which have their respective values; but the latter only will be treated in this paper. The advantages claimed for metal crowns are their strength and durability, cleanliness, the restoration of contour and masticating surface, with anatomical accuracy, adaptation to living teeth, retention of much tissue which would be cut away if a porcelain crown is to be used, and prevention of further caries. The disadvantages are, firstly, the opacity which a porcelain-faced tooth presents, and since translucency is characteristic of natural teeth and is possessed by the porcelain crown, many dentists prefer them for use in front of the mouth; secondly, it is urged that the gold ferule causes considerable irritation to the alveolo-peridental membrane, but whether this, when present, is due to faulty manipulation or solely to the presence of the ferule is uncertain. The metal crowns in greatest use are, the Richmond, the Büttner, the Pivot, Collar, and porcelain-faced collar crown.

The Richmond crown, used almost entirely for incisors and canines, is undoubtedly the strongest and most reliable crown for these teeth. It consists of a cap accurately fitting a root which has previously been treated and coned, to which a pin about two-thirds the length of root is soldered. On this base a porcelain tooth—plate or vulcanite—which has been backed is soldered; or to the prolonged pin a tube tooth can be

fitted, which is especially useful for canine teeth. Its construction is well known. The cap should be made of pure gold, size 4, to which is soldered—using No. 00 solder—a thin platinum plate burnished to the root. The tooth is backed with No. 6 plate, and the contour completed with No. 1 solder, so that the previous joints may not re-melt. The pin may be tube gold or platinum alloy. In preparing the root for this crown a buttress of tooth substance should be left, if possible, at the lingual surface, but the tooth should be ground slighly beneath the gum on the labial surface to which the ferule must also be ground. This crown is more suitable for lower bicuspids, in combination with a tube tooth or a Logan, than any other, as in this case the coronal surface shows more than the labial. It is an advantage that the selection of a tooth can be made from the large number of plate teeth, always kept with greater accuracy than is possible with porcelain crowns. Backing the porcelain tooth with platinum is considered to give it a bluish, with gold, a yellowish tint. A translucent edge cannot be given without sacrificing the strength, the backing should then be cut down nearly to the pins; the occluding edge can be strengthened by bending over backing at an obtuse angle.

The Büttner crown has come into prominence lately on account of the saving of time effected by the use of a special set of "levelling and shaping instruments," by which means the root is made circular in form. The instruments are numbered, and a cap can be procured to exactly fit the root thus treated, so that there remains only to mount and solder a plate tooth. The fact that all roots are made circular precludes its use in every case where it would need a large amount of tissue being cut away, which would in the Richmond be retained for the support of the crown, but the shape of the incisor roots is more nearly circular than is generally admitted, and the excision of a small amount of dentine in addition to enamel matters little if the tooth is not materially weakened. The greater ease of application, and particularly the saving of time—a desideratum greatly to be desired—must be balanced against the condemnation this method has received by some. I do not consider it applicable generally to a canine whose root is slightly flattened laterally, or for small laterals in which the dentine is a mere shell.

The pivot, or porcelain and gold crown without a collar, is only useful when a root is much broken down and does not admit of a ferule being adjusted. The pin should be as long as possible, and platinum plate well burnished over the excised portion of the root, which should be sloped from the middle towards lingual and labial surfaces. A partial ferule can be attached to the palatal surface. The form of crown can be used in partial crowns, as in transverse fracture of central incisors if the tooth is not too discoloured. If a tooth is unyielding to treatment after several dressings, drainage can be effected by using a pin with a small central hole, a cap being placed over its exit. To insert, place a wire up the canal beyond the end of pin and use small amount of osteo, withdrawing wire after setting of osteo.

The all-gold collar crown is used for molars and bicuspids. From its use the best results are obtained; it has no match for strength, and being placed in the posterior part of the mouth the objectionable appearance of gold is avoided. They are made in two ways, the seamless method and constructed in sections. The second is the more usual way, it consists of a collar made to fit the root, slightly coned, to which is soldered a plate struck up to represent the natural cusps. The collar should be soldered on the lingual surface, being bevelled and overlapped, as this presents the advantage that if too small it may be tapped on an anvil-horn at the joint, and so slightly enlarged without weakening any part. It should also be cut from the sheet in the arc of a circle to allow for contour. There are many ways in which the crown surface can be obtained, by using die plate and selecting suitable die, or by using fusible metal cast of a natural tooth in mouldine or crown composition, or waxing up cusps and taking zinc cast. Some prefer to strike up cusps from a die and clear articulation by punching out with blunt punch. The cusps should be well strengthened by addition of solder, which will generally be found sufficient to unite crown surface to collar. If a series of dies, as the Melotte series, is used, it will be found advantageous to take zinc counters, which will bring out the fissures much more sharply. If a die plate is used, the sharp edges should be smoothed with a small corundum wheel. To test the fit of the collar use a Donaldson bristle, the hook of which has been cut off. The seamless crown can be got ready made, or can be swaged from a seamless cap, which is placed in a sectional casting of neck and masticating surface, and burnished to the form of these dies. There are many difficulties in the use of the crowns such as Jüterbocks, which can be obtained at the depôts; their use is limited to normal articulations and normally-shaped teeth. The size of the root must be ascertained carefully by calipers, and crown chosen slightly smaller than the length found, as it is easy to expand, but more difficult to contract. If too small, fill crown inside with hard gutta percha, allow to cool, then cut a wedge-shaped piece to admit flat-nosed pliers, and expand sides evenly. To diminish sides cut V-shaped pieces out of labial and buccal surfaces, and solder in alcohol flame. The sides and cusps can be strengthened by the addition of solder. As now made, they lack contour, which means loss of masticating surface, and leaving V-shaped spaces in which food can lodge.

The collar crown with porcelain face. The application of a porcelain face to the all-gold collar crown requires considerable skill and practice, but makes a crown of greater value where the external surface of the tooth is much in view. To the bicuspids of the upper jaw this is an essential addition. There are several ways in which this is done. A Richmond is made in the usual way, and the palatal cusp made up by soldering pieces of plate to the cap, which is finished and shaped afterwards. Or

to the Richmond is soldered a cap struck up to represent the cusps as in all-gold crown. This cap is attached to the occluding edge of the porcelain tooth by waxing—inverted and intermediate space after boiling out wax filled in with gold plate and solder. The best result is, however, obtained by making a collar fitting a porcelain tooth in buccal surface, soldering and taking a cast of cusp, strike up occluding surface and soldering to collar and backing. The porcelain should always be overlapped by the gold, as its liability to fracture is greatly diminished without losing its advantages. The best plate-tooth to use is the mock or shell bicuspid, the shoulder of which can easily be backed with the usual backing. In soldering the collar, the joint should be made on the buccal surface, then the lingual surface presents no join, which is beneath the gum margin on opposite surface.

When the labial part of the tooth is cut beneath the gum line a piece of thin platinum plate should be soldered to the thin band encircling this part—this keeps it in accurate position; the tooth can be fitted to it, and it can be burnished to the edge of the backing and soldered, and so make a tight joint at this edge.

A few remarks as to the preparation of the root and fixing will bring my paper to a close. A great deal of pain may be saved by the use of a 10 per cent. or 20 per cent. solution of Cocaine applied to the gum for several minutes frequently during the operation. The coning of the root must be only slight, rather inclining the parallelism of the walls. Where a root has lost by caries a part of one of its surfaces beneath the gum margin, it can be made up with amalgam. Additional support can be given to collar crowns by the insertion of a pin into the root canal; those devised by Mr. Newland-Pedley for his crowns, especially that for the first bicuspid, taking no time to insert, answer admirably. There have been many ingenious ways of combining a gold band with porcelain teeth, for instance, with the Logan, which greatly enhances their value; and a crown has been made by fitting an aluminium band round molar and making up cusps with amalgam. If a tooth is much decayed the collar can first be made, and rubber dam applied in order to treat the roots to the band.

Whatever may be our opinion as to the utility of bridge work, the strain of mastication being borne by fewer teeth than Nature intended, the system of crowning seems to me to be carrying out Nature's intentions, restoring to the root the work required of it, and therefore admits of no uncertainty as to its application, but the most essential requirement of the practice of bridge work is a thorough and critical knowledge of crowning in gold. The fixing of crowns is generally performed in two ways, by gutta percha and osteo. There are many advocates of gutta percha as a means of fixing all crowns. The root is dried, wiped out with chloroform and packed with base-plate gutta percha, a hole is then made by using a Logan pin, or tube wire and Richmond pin and cap carefully warmed, a little placed in cap and forced home. In this way the crown can be easily removed if necessary at any time, by simply warming a pair of pliers and grasping the crown. The apical foramen must be first filled with osteo.

Cementing with osteo is usual, and makes a more rigid setting. It is best to have a small hole in a furrow of an all-gold crown, through which excess may escape, which may be filled at any time after setting. The osteo should be mixed very thin, and the nerve canal mopped out with the liquid if a Richmond is being fixed.

In concluding my paper, gentlemen, I must thank you for your kind attention, and hope that in the discussion which will follow you will glean some useful hints from the experience of others, which will make up for the many defects of my paper.

The Chairman thanked Mr. Plumley for his interesting paper; he agreed with him that crowns were of great value, and mentioned the increased popularity of crown-work in recent years.

Mr. Goadby asked what would be the treatment of chronic abscess in a crowned root, he also wished to know why crown work was always called the "American system," and whether it originated in America.

Mr. Snell thought that gold-plate overlapping the tooth in a porcelain-faced collar-crown was objectionable, and asked whether a broken-down root built up by amalgam was ever entirely satisfactory for crowning.

Mr. Payne mentioned that he had used amalgam in some instances to fix the pin of a crown in a root with great success.

Mr. Badcock objected to the use of pure gold for metal crowns as being too soft; he used 20-carat gold, as it is pliable enough without stretching. He also described an amalgam crown, made of an ordinary metal collar filled in with amalgam. It is of great advantage in broken down roots and can be completed in one sitting.

Mr. Naish and Mr. Jacobs also discussed the subject.

Mr. Plumley having suitably replied, a vote of thanks was passed to him for his excellent paper, and the Chairman having announced that the next meeting would take place on November 12th, the meeting terminated.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. G. H. WELLS.

NOTICES.

R. J. R., LOWESTOFT.—Microscopic examination of the membrane showed the presence of Leptothrix Buccalis a large number of cocci, some short bacilli, and a few torulæ, but nothing resembling the diphtheria bacilli. After twenty-four hours' incubation on blood serum several raised, rounded, white colonies had made their appearance, which microscopically consisted entirely of *cocci*.

R. J. R., LOWESTOFT.—Microscopic examination of the membrane showed the presence of a large number of medium-sized bacilli, the Leptothrix Buccalis and some cocci, but nothing resembling the diphtheria bacilli. After twenty-four hours' incubation on blood serum a number of whitish colonies had made their appearance. Microscopically these consisted entirely of cocci arranged as staphylococci.

J. R. B., SUTTON.—No tubercle bacilli could be found in the specimen.

F. R. B. B., TUNBRIDGE WELLS.—A large number of bacilli was present in the sputum, but no tubercle bacilli could be found.

I. M. O., FISHGUARD.—Microscopical examination of the membrane itself shows the presence of cocci arranged as staphylococci, a long slender bacillus, and also a bacillus suspiciously like the diphtheria bacillus. After twenty-four hours' incubation on blood serum, a few small whitish colonies had made their appearance, which microscopically proved to be composed of the Klebs-Löffler bacilli in almost pure culture.

H. R., COMMERCIAL ROAD.—*Tubercle bacilli are present* in the sputum in small numbers. PATHOLOGIST

Appointments.

BRODRICK, C. C., L.R.C.P., L.R.C.S. Edin., has been appointed Medical Officer of Health for the Tavistock Rural Sanitary District.

FOX, J. A., L.R.C.P. Lond., L.R.C.P., L.R.C.S. Edin., L.S.A., has been appointed Medical Officer and Public Vaccinator for the No. 1 District and Workhouse, Penzance Union, vice A. W. T. Steer, resigned.

KENDALL, BERNARD C., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer for the Windron District of the Helston Union, vice C. F. Seville, M.B. Lond., resigned.

PARE, J. W., M.D., C.M. Edin., L.D.S., has been appointed Lecturer on Dental Anatomy and Physiology to the National Dental Hospital, vice Sidney Spokes, resigned.

POLLARD, CHAS., M D. Brux., F.R.C.S. Eng., L.R.C.P. Lond., has been appointed Medical Officer and Public Vaccinator for the Halt District of the Martley Union.

SELLS, C. J., L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer for Worplesdon, Guildford Union.

Sport.

Association Football.

TRIAL GAME,

Played on Wednesday, October 5th, in a pouring rain, which may account for the rather feeble display. Very few Freshers put in an appearance, but of those who did, none showed form good enough for the first team. At present, Ford, a second year's man, seems to be the only one who is likely to figure in the first team; his play has improved wonderfully since last season, and he ought before long to make a really good forward. The half-backs are numerous, but not quite good enough, though we hope they will improve in form while playing for the second. We are still sorely in need of a good back, and hope to find one shortly.

Rugby Football.

ROSSLYN PARK v. GUY'S.

The opening match of the season was played on October 5th, at the Old Deer Park ground, Richmond. The weather was miserable, and during the whole time the game was proceeding a drizzling rain fell, but in spite of the unfavourable weather, the ground was in fine condition. Guy's had many notable absentees, viz., Alexander, Tyson, Jackson and others. These for various reasons were unable to play, but this circumstance gave a good opportunity for "new blood" to distinguish itself, and judging from the play of some of our forwards, it looks as if Guy's will have a very respectable pack to rely on to win our matches this season; for certainly, when they have got together, they ought to be a very hard lot to beat. This latter remark, however, can hardly be applied to our three-quarters, for at no time during the game did they show the slightest sign of combination, and the passing was very erratic and slow; tackling and drop kicking likewise will have to be considerably improved. The halves in the first half did not greatly distinguish themselves, but, in the latter half, Gardner played a very fine defensive game, and by his excellent tackling, saved us on several occasions when a score seemed almost certain.

The ball was started at 3.35 (Guy's having the wind at their backs), a good return was made and the game settled down in mid-field.

At the first scrum it was seen that our opponents' forwards were much quicker in breaking up and in getting the ball out, but doubtless in this respect our men will improve as they get more together. From some loose play which followed, Gwynn by a smart dribble carried the ball to our opponents' 25, but on nearing their back division kicked the ball right into the hands of one of their three-quarters, who took a "punt" to mid-field. From a scrum in mid-field the Rosslyn three-quarters obtained possession of the ball, and by a fine

run their right outside obtained a try, far out by the touch line; from the place kick nothing followed. Dykes dropped out for us, and from some scrambling near the centre line a penalty kick was claimed, but nothing resulted, and whistle blew half-time leaving the score in Rosslyn Park's favour by a try to nil.

On changing ends, we started with the wind in our faces. The Rosslyn forwards now pressed hard, and quickly carried the game into dangerous proximity of our goal; an ugly rush made by one of our opponents' three-quarters was well stopped by Wood. Guy's forwards now carried the ball well away from their goal, but from a throw out from touch, and by smart passing by a Rosslyn half, one of our opponents' three-quarters was enabled, after a good run, to cross our line, but in endeavouring to get behind the posts he got outside the 25-yard limit. Dykes dropped out, but nothing of note occurred, and the game was kept just outside our territory. After a series of scrimmages, Rashleigh by a fine dribble carried the ball to mid-field, but our opponents were not to be denied, and after some accurate passing by their back division, their outside left three-quarter made a dash, and crossed our line close by touch. The place kick failed, the ball falling wide. The whistle now blew time, leaving Rosslyn Park the winners of a good game by two tries to nil. Team:—

Guy's.—E. Ensor (back); F. L. Rae, F. C. Wetherell, F. Sime and H. K. Lacey (three-quarter backs); M. P. Jones and J. N. Gardner (half-backs); E. G. Goddard, P. A. Dykes, P. D. Hunter, W. P. Gwynn, W. Rashleigh, H. V. Bagshawe, A. H. Carter and M. D. Wood (forwards).

A trial match was played on Thursday, October 3rd, at Honor Oak, when there was a good turn out. We were very glad to see such a number of new men. The sides were captained by R. S. Rowland and P. A. Dykes, and a good game resulted in a win for Dykes' team by 2 tries to 1 goal. Of the freshmen, Sime was the best amongst the backs: he has a good pace and runs strongly, but must improve his kicking. Gardner was tried at half; his passing was very clean, and he is worth trying again in this position. Gwynn promises to be an acquisition to the forward ranks; he is good out of touch, and works well in the scrum. Bagshawe and Carter also played a hard game.

The following matches have been arranged for the 3rd team:—

Oct.	5.	Upper Clapton III.	Away.
	19.	Streatham III.	Home.
Nov.	16.	Blackheath Proprietary	Away.
	23.	St. Thomas's Hospital III. ...	Away.
	30.	Bromley II.	Away.
Dec.	14.	West London II.	Away.
Feb.	15.	Old Charltonians	Away.
Mar.	7.	Blackheath Proprietary	Away.

Other fixtures will doubtless be arranged soon.

Guy's Hospital Swimming Club.

This has been a most successful year for the club. The privilege of cheap tickets to members has induced a large number of men to join, and the finances are in an extremely good condition.

Six polo matches were played, of which four were won, one drawn and one lost. The winning matches included the Otter Swimming Club match.

Several good men came up this year, the best of whom, Styer, was a host in himself, as the spectators of the Cup ties can vouch. Every member of the team worked hard.

The Inter-Hospital Cup ties have resulted in our bringing the Cup home for the first time. With present form, we ought to retain it easily, and for the maintenance of that form we look to the new men.

HALLAM HARDY, Hon. Sec.

Guy's Hospital Dental Department.

Practice during August, 1895.

Gold Fillings	240
Plastics	243
Artificial Crowns	25
Dentures	6
Devitalized Teeth	73
Scalings	33
Regulations	4
Attendance for Extractions under Anæsthetics ...	1082
,, ,, without ,, ...	786
Total	2492

Practice during September, 1895.

Gold Fillings	163
Plastics	231
Artificial Crowns	20
Dentures	12
Devitalized Teeth	76
Scalings	14
Regulations	4
Attendance for Extractions under Anæsthetics ...	1090
,, ,, without ,, ...	887
Total	2497

Birth.

ALSTON.—On September 11th, at Wheathampstead, Herts, the wife of W. Evelyn Alston, B.A., M.B., B.C. Cantab, of a daughter.

Marriages.

WASON—WARNE.—On September 3rd, at Amberley, Gloucestershire, by Rev. G. Fox, Vicar of Stroud, Richard Llewhellin Wason, M.R.C.S., L.R.C.P., to Mary Kathleen, second daughter of Edward Warne, late of Spring Grove.

ASHWELL—LYON.—On September 25th, at Pontefract Parish Church, George Ashwell, M.R.C.S., &c., of Nottingham, to Elizabeth Beatrice Lyon, eldest daughter of Mr. J. G. Lyon, J.P., of Carleton Close, Pontefract.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

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The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

OCTOBER 26, 1895.

A Case of Mitral Stenosis with Multiple Emboli.

CLINICAL LECTURE BY DR. FREDERICK TAYLOR,

On October 5th, 1895.

The case which I want to consider to-day is that of a woman, æt. 29, who is married, and has had one child three years ago. She was admitted for loss of power in the left arm and leg. She had rheumatism when she was 17 years of age.

Three weeks ago she was delivered of a child, and the doctor who attended her says that the labour was quite straightforward. She had a discharge, which disappeared in ten days. On September 25th, at 6.30 a.m., the patient fainted, and when she recovered consciousness she found that she had lost power in her left arm and leg.

On admission.—It was seen that the left arm and leg were paralysed, and that these limbs were cold. The pulse could not be felt in the left arm. There was some facial paralysis on the left side. Patient had retention of urine. The urine contained a trace of albumin.

On examining the patient more thoroughly the next day but one, it was found that she could move the left arm a little. The pulse could not be felt in the radial or ulnar arteries, but could be felt in the brachial at the bend of the elbow. The leg was almost completely paralysed, and the parts of the leg about the ankle and the foot were becoming gangrenous, having a dark blue colour. The pulse could not be felt in the dorsalis pedis, in the peroneal or in the popliteal artery. Pulsation was felt in a small artery just above Poupart's ligament, but no pulsation could be made out in the femoral itself, which was felt as a hard cord.

On examining the heart, it was found that there was a loud presystolic bruit, and some doubt was felt as to whether there was also a slight systolic. On making an examination of the eye, no change was found in the optic disc or in the retina. It was found that there was very little paralysis of the face now.

On the night of the second day after admission, the patient had an attack of convulsions affecting the left side, the head being turned towards that side.

On reviewing this case we see that it is practically clear up to a certain point. The patient had rheumatism when 17 years of age. She has a presystolic bruit, which in this case undoubtedly means mitral stenosis. Five days before admission she was taken with a fainting attack, and when she was brought round she was weak and paralysed on the left side. The vessels of the limbs were pulseless, and the left foot and lower part of leg were becoming gangrenous. There was very slight facial paralysis.

First, considering the mitral stenosis and the history of rheumatism, we know that the result of such a lesion may be the carriage of a piece of fibrin from the affected valve into other parts, the process being known as embolism. If we assume that this is a case of embolism we see that this would explain all the symptoms given above, the emboli being lodged in the left brachial artery, in the femoral artery, and in the right middle cerebral artery. That the last artery contains an embolus may be uncertain, but that the first two are obstructed cannot be doubted.

Before proceeding further with the case, I may say a few words on the conditions known as embolism and thrombosis. I speak of these together because they both affect the blood vessels, and it is useful to contrast them. Some confusion is also often entertained as to their true meaning. I am inclined to believe, however, that this arises because not enough trouble is taken to ascertain the exact meaning of the words themselves. If you will look in your Greek dictionaries you will find that "Thrombus" means a "lump" or a "mass," especially "a clot, or gout of blood." But in medicine the term is limited to a coagulum of blood formed during life, either in a vessel or in a cavity of the heart, *i.e.*, in the vascular system. A mass of clot under the skin, as the result of an injury, would not be called a thrombus. "Embolus" means something "cast in" or rather "impacted in," *i.e.*, something projected along a vessel and subsequently fixed in that vessel.

A thrombus almost always is formed in a vein, because the conditions favouring coagulation are more often present there. The most important of these conditions is the slowness of the blood-stream; but occasionally, when there is some pathological change in the walls of an artery, a thrombus may be formed within it.

It is clear that embolism cannot take place in the veins, because if any object of the nature of an embolus enters a vein, it must pass from narrower to wider vessels, so that it cannot possibly become impacted. On the other hand, any object entering an artery is driven from wider to narrower vessels until it meets with one through which it is too large to pass.

Thus we see that while thrombosis nearly always takes place in a vein, embolism always takes place in an artery. This is as true of the pulmonary as of the systemic vessels.

Again, there are different kinds of emboli. One kind is a fragment of fibrin which has been deposited upon a diseased cardiac valve, as is almost certainly the case here. The fibrin, which gradually increases in quantity, becomes too large to remain at its attachment, or it is otherwise detached and a portion is washed away into the vessel. In this case you will see the process of thrombosis precedes and helps to bring about that of embolism. Fat globules under certain circumstances cause embolism. It may be caused by particles of growth which have penetrated through the walls of the artery and are washed away by the blood current; and in a microscopic way by septic organisms. Quite rarely small hydatid cysts may act as emboli. I remember reading of a case in which the popliteal artery had been blocked by small hydatid cysts, which had entered the left auricle, through the rupture of a hydatid cyst in the pericardium.

Further, embolism may experimentally be caused by injecting various minute particles, spores, etc., into an artery.

The general effects of thrombosis and embolism are different, or the same, according as they occur in an artery or in a vein, because both produce these effects by obstructing, the one the veins, and the other the arteries. When a vein is obstructed we get œdema, *e.g.*, thrombosis of the veins of the leg after pregnancy forming phlegmasia dolens, or white leg. It also occurs in typhoid fever, phthisis, and in very prolonged illnesses, such as cancer. If you had thrombosis occurring in an artery, the effects would be very much the same as embolism in an artery: the chief difference being, that the results of thrombosis may be slower in their onset.

The effects of embolism in the artery of a limb are: First of all, pulselessness beyond the embolus, unless anastomosis takes place so as to connect the artery with the part beyond it. The limb is cold. The onset is very often accompanied by intense pain. There is also a certain amount of loss of power and loss of sensation in the limb, the muscles and nerves being badly nourished. The amount of this loss, however, varies a good deal according to the extent to which the embolus blocks the artery. Sometimes it only causes a slight obstruction, at others it blocks the vessels completely. When the obstruction is complete, the part beyond may become gangrenous. In this case the foot and ankle are blue in colour and are becoming gangrenous. Here, you see, only the lower part of the limb is becoming gangrenous, although the embolism has taken place as high as the femoral artery. In the solid viscera the effect of emboli is the formation of infarcts, especially in the spleen and kidneys. If you look at a spleen where this has taken place you will see a whitish-yellow patch on the surface, which corresponds on section to a triangular patch of the same colour. An earlier stage of this is a dark red congested area, due to reflux of blood to the part whose blood-supply has been cut off by the embolus. As a result of an embolus in the brain, softening of the brain-tissue takes place. In the brain also one can often readily tell that embolism has taken place, especially when the middle

cerebral artery is affected, as we then get certain definite symptoms. The motor area is rendered anæmic, and this is followed by paralysis of the muscles of the opposite side of the body.

In the case before us, we are quite clear about the embolism in the limbs and the conditions arising therefrom. But we are not quite so certain that the middle cerebral artery is affected, because some of the weakness of the left limbs might result from the lesions in the arteries of these limbs. Evidence in favour of the cerebral lesion is the partial paralysis of the facial muscles, which would not, of course, be explained by the emboli in the vessels of the limbs. If, when the middle cerebral artery is affected, there is some difference in the amount of paralysis in the leg and arm, the paralysis is almost always less in the leg. In this case the leg appears to be weaker. The suddenness of the lesion is in favour of the middle cerebral artery being affected. Further, since her admission, the patient has had a definite attack of convulsions, in which there was twitching of the muscles on the left side of the face accompanied by deviation of the eyes towards the left, indicating a lesion of the right side of the brain in the motor tract or area. For when deviation of the eyes and head occurs with convulsions, the eyes look away from the lesion; but when it occurs with paralysis, the eyes look towards the lesion. It is unusual that so many emboli should become impacted in various places in such a short period of time, perhaps even at the same moment. The arm is better now in respect of temperature and sensations than when the patient was admitted, but the leg, as we mentioned before, is going on to gangrene. This gangrene is not a necessary result of embolism. It is, as I said before, a question of degree; gangrene, probably, only follows when the obstruction is complete, or supply by collateral circulation is prevented.

We have now to consider how the embolism took place in this case. There are cases familiar to us as malignant endocarditis. In these cases there is a deposition of fibrin on the valves, in association with septic affection of the valves. The process of septic necrosis goes on until a part becomes detached and forms an embolus. The patient suffers from long-continued fever and becomes anæmic. Then, in many of the cases, there is evidence of emboli in the spleen and kidneys. Embolism of the spleen is shown by pain and tenderness, and that of kidneys by albuminuria. The vessels of the limbs also often become obstructed, causing the vessel to become pulseless and occasionally, as already stated, producing gangrene.

This patient is probably suffering from this condition. We know that patients go on for years suffering from cardiac diseases, and then finally septic infection occurs, the patients become febrile, and often die from the effects of emboli.

There is another case in the ward suffering from malignant endocarditis. She has the anæmia and the fever, but she has no signs of mechanical obstruction by emboli.

What is somewhat in favour of this case being malignant endocarditis is the slight rise in temperature; but it is not of itself conclusive proof, since it is slight in degree, and, so far as we know, is only of short duration. Then you may ask:—Is it certain proof of endocarditis if you have undoubted evidence of embolism? By no means. It is well known that there are individuals who have heart disease, and then get embolism of the middle cerebral artery, followed by hemiplegia. But they have no fever, only evidence of a mechanical detachment of fibrin. The attack partly clears up, leaving the limbs paralysed on one side, and the patient may live for years afterwards.

Another point which I want to lay stress on is the importance of using the ophthalmoscope in these and allied cases. In this case our result was negative. Now, we may ask, did we expect to find some change in this case? It is very rarely that embolism is accompanied by any changes in the fundus, so that our result agreed with this fact. But endocarditis is often accompanied by optic neuritis and retinitis, and also sometimes by embolism of the arteria centralis retinæ.

The *prognosis* in this case is very bad. The extent of limb becoming gangrenous is very large, so that the possibility it should recover is out of the question.

The risk to the patient to a great extent depends on the condition of the lower extremity. So far as the arm is concerned, there is no immediate danger. Again, if the leg were amputated after the line of demarcation forms, I am afraid the stump would almost certainly get septic and slough. Even if the stump were to heal, there would be great risk to the patient from the general septic condition.

The *treatment* in this case must be purely symptomatic, and must be directed chiefly to relieve the patient's pain.

N.B.—This patient succumbed on October 15th, and the following lesions were found:—

ABSTRACT OF AUTOPSY.

Arteries and veins.—Embolism at bifurcation of aorta, with thrombus along left common iliac, extending into superficial femoral, also another embolus at bifurcation of brachial and small ante-mortem clot at junction of subclavian and carotid veins; thrombosis of left uterine vein.

Heart.—Weight, 9¾ ounces. Mitral valve, 1¾ inch in circumference, thickened with calcareous mass and recent friable vegetations; left auricle water-marked.

Spleen.—Large and firm; weight, 14 ounces. A large infarct (5½ inches by 4½ inches), occupies two-thirds of it.

Kidneys. — Œdematous; somewhat pale; weight, 9½ ounces; infarct in upper part of right kidney.

Liver.—Weight, 50 ounces.

Brain.—Weight, 40 ounces; small clot at bifurcation of right middle cerebral artery, firmly fixed and adherent to the wall; another more recent dark and firm clot, half-an-inch farther along the same artery. In the right hemisphere there is an area of softening, running along the posterior end of caudate nucleus and extending inferiorly to the posterior half of the lenticular nucleus.

Large tough "cardiac" lungs. Lymph in pouch of Douglas. Moist gangrene of left leg up to the upper third of tibia; toes had become dry. None of the clots were softening. Patient died mainly from the condition of leg.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY	1, 15.	Chlorosis.
	7, 24.	Aortic stenosis and regurgitation.
	12.	Communication between aorta and pulmonary artery. Loud pulmonary bruits and thrill.
	14, 17.	Mitral regurgitation.
	32.	Aortic and mitral stenosis and regurgitation.
	40.	Aortic aneurysm. Aortic regurgitation.
	49.	Mitral regurgitation.
	50.	Mitral stenosis and regurgitation.
PHILIP	4, 9.	Aortic stenosis and regurgitation.
	13.	Mitral and tricuspid regurgitation.
	39.	Aneurysm of thoracic aorta. Aortic regurgitation.
STEPHEN	3.	Adherent pericardium. Mitral regurgitation.
	19.	Aortic and mitral regurgitation. Pleuritic effusion.
	33.	Ulcerative endocarditis.
	34.	Pericarditis. Mitral regurgitation.
	35.	Mitral regurgitation.
	36.	Aortic aneurysm. Aortic regurgitation. Optic atrophy. Jacksonian epilepsy.

Nervous System.

MARY	14.	Chorea.
	16.	Cerebral tumour: optic atrophy.
	19.	Mania following typhoid.
	30.	Cerebellar tumour: optic atrophy.
	46.	Paralysis of right hypoglossal. Secondary carcinomatous nodules in cranial bones.
PHILIP	8.	Left hemiplegia. Granular kidney. Albuminuric retinitis. Retinal hæmorrhages.
	17.	Paraplegia. Myelitis.
	30.	Wrist-drop. Plumbism.
	33.	Ptosis. Deafness. Cerebral syphilis.
STEPHEN	1.	Locomotor ataxy. Optic atrophy.
	6.	Paraplegia. Chronic myelitis.
	10.	Fit. ? Cerebral hæmorrhage.
	13.	Cerebellar tumour. Optic atrophy.
	14.	Aortic and mitral regurgitation.

Alimentary System and Abdomen.

MARY	11, 42.	Gastric ulcer.
	27.	Hæmatemesis. ? Gastric ulcer.
	33.	Perityphlitis.
	47.	Ascites. Tuberculous peritonitis. Lardaceous liver.
PHILIP	10.	Perityphlitis.
	14.	? Gastric ulcer.
	16.	Abdominal tumour. ? Growth. ? Abscess.
	24.	Abdominal tumour. ? Hæmorrhage into gastro-splenic omentum.
	27.	Dysentery.
STEPHEN	7, 27.	Tuberculous peritonitis.
	15.	Hæmatemesis.
	20.	Colic. Plumbism.
	27.	Leucocythæmia.

Typhoid Fever.

MARY	5, 19, 21, 31, 34, 43.	
PHILIP	7, 37.	
STEPHEN	2, 22, 24, 25.	

Genito-Urinary System.

MARY	2, 6.	Tuberculous kidney.
	23.	Granular kidney. Hypertrophied and dilated heart.
	44.	Acute nephritis.
PHILIP	2, 18, 21.	Chronic tubal nephritis.
	12.	Diabetes mellitus.
	23.	Acute nephritis.

Stephen 4. Diabetes mellitus.
31. Chronic tubal nephritis.

Respiratory System.

Mary 18. Dyspnœa. Cyanosis. ? Cause.
20, 26. Pleuritic effusion. Pregnancy.
39. Asthma.
41. Fœtid expectoration. Empyema opening into lung. Gangrene.
Philip 9. Tubercular laryngitis.
3, 28. Pleuritic effusion.
29. Mediastinal growth. Lymphadenoma of intestine.
Stephen 17. Bronchopneumonia.
18. Pleurisy.
24. Pneumonia. Typhoid.

Phthisis.

Mary 4, 38.
6, 9, 37, 39.

Acute Rheumatism.

Mary 14.
Stephen 12, 16, 34.

Miscellaneous.

Mary 10. Eczema.
35. Tinea tonsurans.
Stephen 10. Gout.

Case under Dr. Pitt and Dr. Pye-Smith.

Abdominal Tumour—? Hæmorrhage into Gastro-Splenic Omentum.

Philip 24.—G. N., æt. 20, a painter. Admitted September 27th, for pain in abdomen. Has frequently had slight attacks of jaundice during the last five or six years, which, however, always passed off in a few days without treatment. Two years ago was refused admission into the navy on account of the yellow tinge in his skin and eyes.

Present illness.—On January 21st of this year he was driving a light cart, when the horse took fright and bolted. Patient was thrown out, and the cart was dragged over his abdomen. He was taken to Norwood Cottage Hospital in a collapsed condition. In a day or two he became jaundiced, and this condition varied in intensity during his stay of three months. During the early part of his stay there he had much vomiting, with occasionally hæmatemesis, and several times passed blood per rectum. Temperature variable, and never above 102° F. Three weeks after admission a swelling was noticed in the left hypochondrium, which was very tender, and moved freely with respiration. He was discharged in April, the pain and vomiting having ceased. He kept well until September 21st, when he was suddenly taken with pain in the abdomen, and vomited any food he took.

Condition on admission.—Temperature 100°; pulse 92; respiration 18. Patient has great abdominal pain, and vomits any food he takes. Skin and sclerotics slightly jaundiced.

Abdominal system.—In left hypochondrium is a hard tumour with rounded inferior edge, extending two inches below costal margin, internally, to within three-quarters of an inch of median line. It moves freely downwards with inspiration, and is very tender on palpation. The inner third is resonant on percussion, while the rest is dull, and is continuous with splenic dulness, which extends upwards to the seventh rib in the mid-axillary line, sixth rib in anterior axillary line, and internally as far as the nipple line, and the mass was found to be in contact with the cardiac end of the stomach—this point was determined by dilating the stomach with tartaric acid and bicarbonate of soda.

Liver dulness extends from fifth rib to seventh space in nipple line. Gall-bladder not felt.

Cardiac impulse in fourth space just below nipple. Præcordial dulness bounded above by third rib, below by fifth, internally by left border of sternum, and externally by nipple line.

Urine normal.

Case under Dr. Hale White.

Addison's Disease.

Stephen.—*Admitted for* feeling of weakness.

Family history.—Both parents died when patient was young. No history of tubercle could be obtained.

History of illness.—Twenty-two weeks ago patient caught a cold and suffered from loss of appetite and a feeling of weakness; he tried to continue his work on S. W. R., but had to give it up, and took to his bed, where he has been ever since. Since patient has taken to his bed he states he has suffered from weakness, pain in different parts of body, insomnia, and vomiting. He was strictly kept on milk diet, and was unable to keep anything solid down. Bowels have been confined.

Condition on admission.—Pulse 82; respiration 20; temperature 97·4°. General appearance: skin over face, forearms and penis very dark; several patches of pigmented mucous membrane in mouth; fingers dark, and of a mulatto tint; nipples are dark. Heart sounds are normal, but very feeble. Pulse feeble; præcordial dulness is diminished. Chest is emphysematous.

Progress and treatment.—Patient was given tabloids of suprarenal capsules, which appeared to do good, in that his pulse was more forcible, and heart sounds better marked. Patient himself stated he felt better. The day after the suprarenal were first administered temperature rose to 101·2°; it afterwards continued normal till the evening of his death, when it rose to 102°. Patient was found dead at 11 p.m., twenty days after admission.

At the autopsy both suprarenal capsules were found considerably enlarged, hard and caseous; a few drops of pus oozed from the left. Calcareous nodules were also found in the liver and thyroid gland.

In the Surgical Wards.

Cases under Mr. Howse.

Accident	20.	Dislocation of hip on to dorsum ilii. Fractured pelvis.
	30.	*Dislocation forwards of head of radius* with fracture.
Charity	8.	Varicose veins.
	9.	Enlarged thyroid.
	16.	Necrosis of lower end of femur.

Cases under Mr. Davies-Colley.

Lydia	8.	Contracted knee after popliteal abscess.
	12.	Congenital talipes equino-varus.
	18.	Spinal caries. Psoas abscess.
Luke	1.	Flat-feet.
	16.	Malignant growth in nose. ? Primary in ethmoid.
	21.	Varicose veins.

Cases under Mr. Lucas.

Charity	5.	Swelling over inner end of clavicle. ? Gumma.
	Oct.	Nævus of face.
Lydia	13.	Tumour of breast. ? Scirrhus.
Job	7.	Tuberculous glands in neck. Recurrent tuberculous mass in stump left after castration of right testicle for tubercle. Tuberculous vas.

Cases under Mr. Golding-Bird.

Cornelius	13.	Compound fracture of femur.
Lazarus	—.	Bronchocele; uniform enlargement.
	6.	Old empyema.
	7.	Musculo-spiral paralysis following fractured humerus.
	8.	Epithelioma of floor of mouth.
	9.	Separated epiphysis of upper end of femur.
	10.	Ankylosis of jaw following fracture of neck of bone.
	20.	? Enchondroma over parotid.
	21.	Reducible inguinal hernia.
Martha	16.	Epithelioma vulvæ.

Cases under Mr. Symonds.

Martha	13.	Carcinoma in a breast the seat of induration with cysts.
	14.	Bronchocele. Cyst.

Cases under Mr. Lane.

Job	13.	Chronic ulcer in leg. Varicose veins. Ligature of saphenous veins.
	15.	Recurrent epithelioma in glands after excision of tongue.

In the Out-Patients' Department.

Case I.—Under Mr. Lane.

Patient, a boy of 14, employed at Messrs. Smith and Sons' bookstall, came up, giving the following history:—Seven weeks ago he fell on his right knee. There was some local bruising, but no great amount of pain or loss of movement—in fact, the boy has continued at his work during the whole period since the injury. For the last three or four weeks, however, he has noticed the right hip becoming gradually stiffer, inducing a corresponding lameness of gait. He has had no pain in the hip, but has had slight pain along the outer side of the thigh. A doctor was consulted, and was of opinion that the patient had sprained his hip. Plenty of exercise was recommended, and a belladonna plaster applied along the outer side of the thigh.

On examination, it was noticed that Scarpa's triangle was fuller on the right side than on the left, and the head of the femur seemed to be unusually prominent in the upper part of the space. The patient stood upright with his heels together, the right leg being rotated outwards, and the anterior iliac spine an inch lower on the right side than on the left. In walking, the right hip was fixed and the lumbar spine brought extensively into action.

When the patient lay on his back, the thigh could be flexed on the body only by the play of the lumbar spine and rotation of the pelvis. No flexion was possible at the right hip-joint, and rotation and abduction were very slightly, if at all, permitted. The boy was thus unable to reach his foot to take off his boot. On measurement from the anterior iliac spine to the tip of the internal malleolus, a difference of one and a half inch was obtained; and the tip of the great trochanter on the right side was half an inch above Nelaton's test-line. The pelvis was tilted so as to bring the left anterior iliac spine an inch above the right.

Mr. Lane diagnosed intracapsular fracture of the neck of the femur through the epiphysial line, or, as the books would call it, separation of the epiphysis. In passing, he commented on the distinction drawn in the books between fractures and separation of epiphyses; the latter should also be considered as fractures. Thus, what is described as separation of the lower epiphysis of the radius, is in reality a Colles' fracture in a young patient. He remarked that in this case the head was still lying in the acetabulum, and that the lower fragment had been driven in front of and above it, and united to it in that position, thus acting as a physical barrier to prevent flexion on the pelvis. He recommended patient for admission, and proposed cutting down and chiselling away much of the mass of bone formed by the upper end of the lower fragment of the femoral neck, in order to facilitate movement.

Case II.—Under Mr. Dunn.

E. B., a carman, aged 39, came up to the Hospital complaining of headache and pain over the bridge of the

nose, with a thick but bloodless discharge from both nostrils. He first had a thin discharge from the nose three years ago for three months or so. This recurred about a year ago, when the discharge was, according to his friends' account, very foul-smelling, although he himself at the same time lost his sense of smell. This loss of smell and discharge has continued ever since, and six months ago a large piece of bone, about an inch in length, came away, together with a few smaller pieces, occasioning a little bleeding.

Questioned as to previous illnesses, patient seems always to have been very healthy, with the exception of gonorrhœa, of which he says the last attack was about thirteen years ago, and no evidence of syphilis can be made out, except for the loss of hair eighteen years ago.

On examination, the septum nasi was found to be deficient in several places, and patches of bare bone could be felt. There was marked ozæna. Lotio Pot. Permang. pro inj. was ordered.

In a week's time patient came up again to be examined. There was marked improvement, the ozæna being less noticeable, and the pain and headache greatly relieved. Potasium Iodide was ordered, and the lotion continued.

Mr. Dunn remarked that necrosis of the septum, if on one side only, usually resulted from the presence of a foreign body; while if on both sides, it was almost invariably syphilitic.

In the "Charity."

A letter will be found in another column from Dr. George Roper, on our report, in the last issue, of the case of Decapitation.

He enclosed for us an article he presented to the obstetric section of the International Medical Congress in 1881, "On Trismus and Tetanus of the Uterus in Labour."

It is a subject which, as Dr. Roper says, has received little, if any, notice in the ordinary text-books, but as it may occur in the practice of any one of us, it is worthy of more detail. Dr. Roper's paper is a very interesting one, but our space only allows a brief extract of it. Commencing by quoting Spiegelberg's description of the complication, he says:—

"Tonic partial cramp or spastic stricture affects only those muscular fibres which are arranged in the manner of a sphincter. It is observed only at the external or internal os uteri. Stricture of the external os occurs only in the period of dilatation; indeed, in its early stage, and especially in primiparæ, the few cases I have seen concerned only such. The border of the os uteri is persistently tense and hard, sometimes perfectly rigid, and the tension remits at shorter or longer intervals, but never entirely passes off. The tissue of the rest of the uterus is yielding. There is no trace of dilatation of the os during a pain; indeed, there is more apparent narrowing, and the presenting part recedes in an upward direction. At the same time, there is severe pain on touching the os uteri, and spontaneously in the sacrum and thighs. If the uterine muscular fibre is at the same time acting well, then the cervical segment, especially its anterior wall, may be deeply pressed down by the fœtus, and, consequently, the os uteri displaced upwards and backwards, and deep laceration of the border of the os may ensue. This stricture developes itself when the membranes remain entire, as well as after premature rupture of them. Its causes are either rough manipulation, whether for diagnostic purposes or to widen the too slowly dilating orifice, or from metritic conditions, and on this account the prognosis for the lying-in period is not without concern.

The treatment consists in attention to the general conditions, application of warmth (fomentations, baths, irrigation of the vagina) derivatives, as mustard and turpentine to the hypogastric region, and the free use of narcotics. If the stricture remains hard, and threatens danger to the mother or child, then the border of the os should be sufficiently incised. It is better to make one or two deep incisions than many superficial ones. . . . Strictures of the inner os are more frequent than of the outer os. In the dilatation period I have seen it only in premature labour after too early rupture of the membranes; in labour at full term with breech presentation, in which, owing to the presenting part being so swollen, it was mistaken by the practitioner for a new growth; twice in cross presentations, with premature rupture of the membranes. Mostly the stricture is observed in the expulsive stage. . . . Its causes are, early escape of the liquor amnii in pelvic and cross presentations, untimely pulling on the presenting part, over-stimulation of the muscle generally, the improper use of ergot, chilling of the lower parts of the body, and metritis." Dr. Roper gives an account of four cases which occurred under his own observation:—

Case 1.—Placenta prævia in a primipara at the end of the eighth month of pregnancy. Flooding had commenced five days before Dr. Roper saw her. At the end of the fourth day the family doctor had ascertained that the case was one of central placenta prævia. At this period, he ruptured the membranes and separated the placenta, and afterwards there was no flooding. The os uteri was the size of a florin, and so rigid and tense that dilators had no effect in causing expansion of it. Next day, the os uteri was found in the same rigid and unyielding condition. She was put well under chloroform and version was tried. The bipolar method was impracticable. The os rather contracted than expanded when attempts were made to dilate it. Chloroform in no degree diminished the spasmodic rigidity; and while the patient was fully under its influence, five or six of Barnes' dilators were burst in attempts at expansion without producing the desired effect. The patient was then left for six hours, and Dr. Braxton-Hicks met them in consultation. Dr. Hicks was unable to introduce his hand through the resisting os, but, with a long crotchet, a hold was obtained on the ribs, and by forcible traction the child

was somewhat moved; afterwards, with a small, long, blunt hook passed up through the os, Dr. Hicks succeeded in catching a knee, which was brought down. Much traction was required to deliver the child. The patient died two hours afterwards.

Case 2.—Premature labour, placenta felt within the cervical zone of the uterine cavity; hæmorrhage; transverse presentation; trismus and tetanus of uterus; delivery by decapitation; recovery of mother after long and severe illness.

Case 3.—Placenta prævia; premature labour; oblique presentation; trismus of the uterus; difficulty in extracting the child; mother died undelivered.

Case 4.—Placenta prævia (full term?); transverse presentation; trismus and tetanus of the uterus; difficulty of version (podalic); evisceration of fœtus; death of mother two hours after delivery.

"Now, it is important to distinguish trismus of the os uteri from all other forms of obstructed labour. The affection must be recognised as an exceedingly rigid and tense state of the os and cervix uteri from spasmodic contraction alone, all cases of rigidity of the os resulting from structural changes of the uterine tissue being excluded.

The minor causes—as rough manipulation for diagnostic purposes, stretching the os uteri mechanically, premature rupture of the membranes, and the indiscreet use of ergot—may be passed over without remark.

Dr. Barnes ("Lectures on Obstetric Operations,") says, in speaking of the condition commonly present in placenta prævia:—"The first is an immature uterus. Flooding frequently occurs before the full term of gestation is complete. The uterus is, therefore, taken by surprise, before its tissue is developed—before it has acquired its normal contractile power; besides this, the tissue is ill-adapted to expand."

Uterine polarity seems to afford a rational explanation of trismus in labour before full term. At a premature period, fundal polarity has not become established, whilst cervical polarity remains in force; hence there is in premature labour as connected with an immaturely developed cervix, a degree of what may be called trismus, to which is superadded the morbid rigidity of a spasmodic kind.

The behaviour of the uterus in ordinary transverse presentation, differs much from that observed in transverse presentation combined with trismus. In the former, the uterus often remains passive, as if conscious of the difficulty with which it has to deal, even although the os uteri is soft and largely dilated, but as soon as the malposition is rectified, rhythmic, vigorous action ensues, and expulsion of the child is readily effected. Occasionally, however, the uterus in like circumstances, does not remain passive, but acts with great violence, even to the extent of expelling the child by way of spontaneous evolution.

The conduct of the uterus in transverse presentations with trismus affords a great contrast to this. After version, rhythmic expulsive action rarely occurs, and there is no tendency of the uterus to act and expel its contents.

The body of the uterus, whether it be in active or in tetanic action shows no disposition to force the child through the spasmodic os. Traction on the leg to assist delivery seems to render the os even more spasmodic, and the progress of labour is rather retarded, than expedited, by such attempts. The os tightly grasps the thigh of the child, and obstinately resists the passage of the half-breech through it. We may leave the fœtus for many hours, with one of its lower limbs firmly held in the os, and yet no expulsive effort is set up by the uterus. During a long period there is no progress towards delivery, and with the advent of exhaustion, the child has to be extracted by force, or by some mechanical means, or the mother left to die undelivered.

Between trismus and tetanus in an early stage of labour, and the tetanus of the exhausted uterus after severe labour, there is this resemblance: they both lead to death in the same direction. Firstly, by exhausting the nerve-force of the uterus, then of the ganglionic system generally. In each case there is no interval of ease during which a fresh store of nerve-force can be generated. There are, however, strong points of difference between the two kinds of cases. The tetanus of exhausted labour occurs at the end of the second stage of labour, after severe and long-continued action of the uterus in insuperable obstruction; whereas trismus occurs at the beginning of the first stage of labour, without any previously severe action of the uterus. The condition of the uterus in the one case is initial, in the other it is terminal.

Treatment.—(1) The first and chief object is to subdue the spasm of the os and cervix, for this is the source of the difficulty. Without affecting this we shall not be able to do with safety what is required, whether we have to deliver by force a child normally placed, or by podalic version in case of malpresentation.

(2) The common soothing methods, as vaginal irrigation, etc., are useless.

(3) Opium does not materially help us.

(4) Chloroform is valueless so far as regards subduing the uterine spasms.

(5) Mechanical stretching of the os rarely succeeds.

(6) Incision of the os has yet to have its value proved by further experience.

(7) What benefits are we to derive from expectancy? In all the reported cases the patient died undelivered by being left.

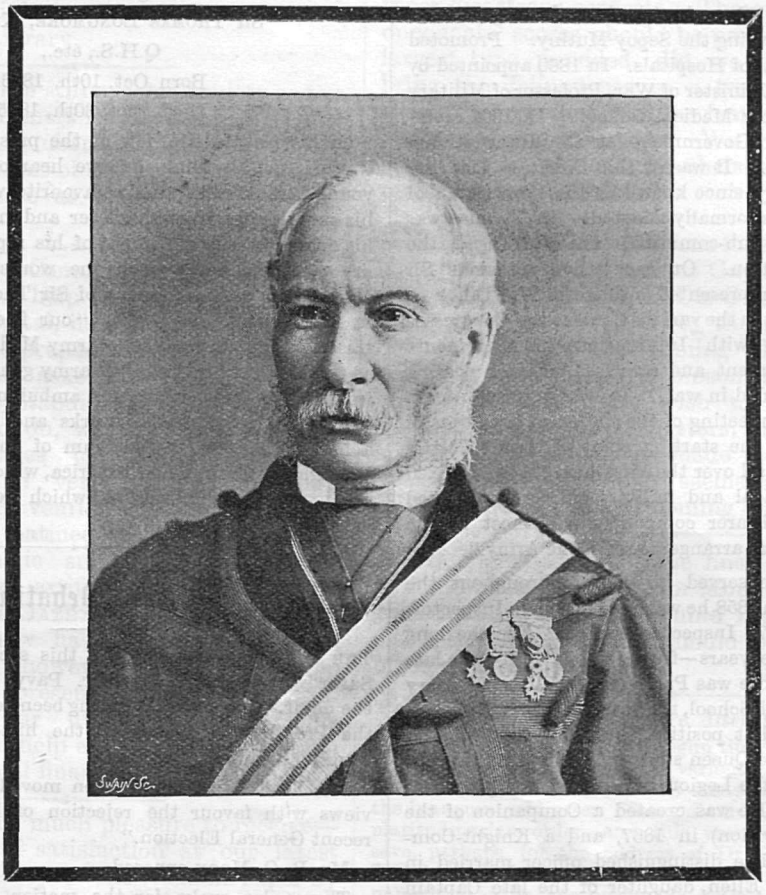
(8) As transverse presentations so frequently occur in conjunction with trismus, version of the child will often be a necessary part of treatment. This operation will be found difficult in proportion to the degree of tetanus. With trismus simply the bipolar method may succeed; but not when tetanus exists. But by whichever method we succeed in effecting version, then comes the great difficulty in extracting the child through the spasmodic os.

(9) Decapitation."

H. W. C.

Obituary.

THE LATE SIR THOMAS LONGMORE.



[*By kind permission of the Editor of* The Lancet].

On Monday, September 30th, at Swanage—where he was a frequent visitor—this well-known member of our profession, and much honoured twig of the Guy's tree, passed away. Sir Thomas had retired from the Army Medical Service in 1891, as Surgeon-General, and at the time of his death held, amongst other honours, the post of Hon. Surgeon to the Queen, and was also Knight Commander of the Bath, and Chevalier of the Legion of Honour, the insignia of which he was by Royal Licence permitted to wear. The suddenness of his death is shown by the fact that the deceased was in his usual health, seeing his son off by the 6.20 a.m. train, and before eight o'clock he was dead. Since his retirement from active service he had made Woolston his home, and was held in the highest respect, not only amongst the members of his profession, but by all with whom he came in contact.

Sir Thomas Longmore was the son of the late Thomas Longmore, surgeon Royal Navy, by Maria, daughter of John Elcum. He was born in Southwark on October 10th, and in a few days would have reached the advanced age of 79 years. He was educated at Merchant Taylors' School and at Guy's Hospital. When here he "dressed" to Mr. Bransby Cooper, whom he also assisted privately, and in writing the life of Sir Astley Cooper. In 1843, he entered the Medical Department of the Army, became Surgeon in 1854, and Fellow of the Royal College of England in 1856. He served throughout the Crimean campaign of 1854–5. With regard to the details of this portion of his career, the following extract from a letter to the *Hampshire Advertiser* is of interest:—

"Sir Thomas served in the 19th Regiment in the Light Division of the Eastern Army from its first taking the field throughout the campaign of 1854-55 until the termination of the siege of Sebastopol, and was not absent for one day from duty during the campaign.

Present at the affair of Bulganne, battles of Alma and Inkerman, capture of Balaclava; assaults of the Redan 18th June and 8th of September, for this service medal and three clasps, Turkish medal, and Knight of the Legion of Honour. Served with the same regiment in Bengal in 1857-58 during the Sepoy Mutiny. Promoted to Inspector-General of Hospitals. In 1860 appointed by Lord Herbert, then Minister of War, Professor of Military Surgery in the Army Medical School. In 1864 represented the British Government at the International Congress at Geneva. It was at this Congress that the International Treaty, since known as the Convention of Geneva of 1864, was formally adopted. Sir Thomas was a member of the sub-committee that arranged the articles of Convention. On ten other occasions Sir Thomas Longmore represented either the War Office or British Government in the various Continental Congresses appointed to deal with International arrangements regulating the treatment and arrangements for dealing with sick and wounded in war. It was a paper of his used at the annual meeting of the Order of St. John of Jerusalem that was the starting point of the St. John's Ambulance classes all over the kingdom. With a mixed committee of medical and military officers, he assisted in organising the bearer companies and most of the existing field hospital arrangements of the Army."

From 1857–59 he served in Bengal throughout the Indian Mutiny. In 1858 he was made Deputy Inspector-General, and in 1872 Inspector-General. For the long period of thirty-one years—from 1860 to 1891—the late Sir Thomas Longmore was Professor of Military Surgery at the Army Medical School, the Royal Victoria Hospital, Netley, resigning that position in 1891. He has been Hon. Surgeon to the Queen since 1868. In 1857, he was made a Knight of the Legion of Honour, and promoted to officer in 1879. He was created a Companion of the Bath (military division) in 1867, and a Knight-Commander in 1886. The distinguished officer married in 1862, Mary Rosalie Ellen, daughter of the late Captain W. S. Moorsom, of the 52nd Regiment. He was the author of various valuable professional works, the chief amongst which were "The Optical Manual," "A Treatise on the Transport of Sick and Wounded Troops," "Essay on Gunshot Wounds," Holmes' Surgery, "Sanitary Contrasts of the Crimean War," "On Heat Apoplexy"—Indian Ann. Med. Sci., "Osteo-myelitis after Gunshot Wounds," and "Gunshot Injuries: their History, Characteristic Features, Complications, and General Treatment."

The late Sir Thomas Longmore did not take an active part in public affairs, but he showed a great interest in the Southampton Free Eye and Ear Hospital, of which he was Consulting Surgeon.

The funeral took place at Hamble, where the deceased especially desired to rest. There, on October 3rd, a large assembly of notabilities in the Army Medical world and friends paid the last honours to our distinguished brother. The remains were enclosed in an outer coffin of massive oak, unpolished, with brass furniture, on the breast-plate being the inscription, handsomely illuminated:—

Surgeon-General
Sir Thomas Longmore, Kt.C.B.,
Q.H.S., etc.,
Born Oct. 10th, 1816.
Died Sept. 30th, 1895.

Of his private life, few of the present generation at Guy's know anything, but we hear of him as kind to young and old alike, and a favourite with all owing to his singular charm of character and mind; the force of his character and the height of his reputation at Netley are well demonstrated in the words of Sir William Mackinnon, on the occasion of Sir Thomas's retirement in 1891, when he said that "our friend has not only raised the reputation of the Army Medical School as well as the Medical Service of the army generally by his great works on military service and ambulance transport, and by his many admirable works and reports, but has achieved, through the medium of these, a reputation throughout Europe and America, which reflects infinite credit upon the service of which he is so bright an ornament."

Guy's Hospital Debating Society.

The twenty-first meeting of this society was held on Saturday, October 19th, Dr. Pavy, the President, in the chair. The minutes having been read and confirmed, the President briefly traced the history of the society from its formation.

Mr. F. E. Fremantle then moved that "This house views with favour the rejection of local veto at the recent General Election."

Mr. R. O. Moon opposed.

There also spoke for the motion, Messrs. Howard, Pakes, and Reaside; against the motion, Messrs. Jackson, P. C. Higgens, Spriggs, Ormond, Croucher, Hamblin-Smith, and Anderson.

The openers having replied, the house divided and there voted thus:—

For the motion	...	...	12
Against the motion	...	...	15
Majority against	...	...	3

A vote of thanks to Dr. Pavy was then passed, and the house adjourned.

The Committee are anxious to bring before the notice of junior men that the Debating Society is a constituent institution of the Clubs' Union, and that all members of the Clubs' Union are members of the Debating Society. They trust that some members of the first and second years will speak at the meetings of the society; the future of the society being dependent upon the addition to its speaking members of men in the junior years.

Passim.

To-night, at 8 p.m., the Physical Society holds its first Clinical evening of the session, in the Hospital Library.

The Residents are still in some anxiety as to a sufficiency of performers for the opening Smoker next Saturday, November 2nd; we do not doubt there will be a surplus of audience. The willing should communicate as soon as possible with the President.

The Temporary Committee of our Present Students, formed to help to defray the annual deficit on the Hospital, held a crowded meeting last week. On the proposition of Mr. Reaside, the Residents were asked to become for their period of office a Standing Committee, which they consented to do, with absolute power to form sub-committees for special entertainments. Many and very practical ideas for money-getting were ventilated, amongst which were a bazaar, a matinee, amateur theatricals, a concert, a public smoker—in fact every supposed or known artifice to fill the coffers of the treasury. The Gazette has supplied many wants, but till now has never posed as a begging agency; however, we cannot help thinking that the present exceptional circumstances demand our utmost efforts—feeble though they be—to help even the most sceptical to realize our critical financial position.

It has afforded us much pleasure to receive—as an expression of satisfaction at our latest effort, "In the Charity"—the valuable paper by Dr. Roper, supplied through the kindness of the Senior R. O. A brief abstract appears in this issue of its salient points.

We have been asked to call attention to the rule that enquiries at the Medical School Office should be made before one o'clock. It can but seldom happen that a question that arises in the afternoon cannot wait for an answer till the next morning. The door is left unfastened between one and five to meet the cases of such rare emergencies, but unless it is used with discretion during these hours it may become necessary to close it absolutely.

Anyone wishing to read a detailed account of the Blackheath and Cambridge matches in our pages to-day, and searching in vain, should think charitably of the Rugby secretary—till lately worried by exams.—and vent their spleen, as seemeth fit, upon those persons appointed by him to send in reports, for these worthies (???) have omitted to supply us with any details of these disastrous contests. The enormity of our opponents' scores should be printed here in the largest type provided, did we think it would bring the delinquents to a true realisation of their shortcomings, but we fear no such subtle jest would appeal to them. We hope that better luck in the field will be their share, and full reports ours in the future.

We all know what happens to the early bird—and there are many such at Guy's, most prominent of which being the "Dis-Guysed," who are even now consulting as to the fare to be set before us all at the coming Christmas-tide. "Massas" Carpmael, Robinson, and Spon, the Nigger sub-committee, wish to hear of any 'jo-ists, joke-ists or songsters, as an "extry speshul" effort is to be made to beat the last year's successes. There seems a fair probability of the nigger tour coming off.

We understand that the final F.R.C.S. Examination has been fixed for Monday, November 18th, and are asked to remind intending candidates that their names should be left at the office without delay.

This from the *Hampshire Advertiser*:—

The Medical Schools have begun their work. October brings back the students to the various hospitals, and the commencement of the season's study necessarily brings the inaugural addresses. These are usually rather of the platitudinarian order, and this year is no exception, save, perhaps, for the address of Dr. Death, of Guy's. The doctor seems conscious of the incongruity of his name, and so he has now made it De'Ath. The doctor certainly uttered some home truths, of which I am suprised to find no greater notice taken. He essayed to speak to the "Bob Sawyers" of Guy's on "our Profession, our Patients, our Public, and our Press," and, according to him, all are about equally unsatisfactory. The Profession boasts its power, and yet leaves the diagnosis of every serious case to a specialist, and its treatment to a trained nurse. Public support, he says, is fascinating but fickle. There is a hit at his professional brethren when he suggests that the sick room ought not to be made the market place of advertising. The names of several prominent physicians come to the mind at once. Dr. De'Ath is very hard on the Press, which, he says, provides generally inaccurate and always inexcusable details from the sick room, but he is harder still on his brethren who get practices by means of "a swagger turn-out, grand-looking houses startlingly painted, gorgeously-dressed wives, and pandering generally to the bare-faced snobbery of modern Society." "A swagger turn-out" can be understood, and so, perhaps, a grand-looking house startlingly painted; but what! oh what! does Dr. Death—I beg his pardon, Dr. De'Ath—mean by "gorgeously-dressed wives?" He at least has no claim to be called a ladies' man.

Annual Sermon.

Preached in Guy's Hospital Chapel on the 17th October, 1895. By Rev. H. C. G. Moule, D.D., Principal of Ridley Hall, Cambridge.

"And the peace of God, which passeth all understanding, shall keep your hearts and minds through Jesus Christ." (Epistle to Philippians iv., 7.)

A few points have to be noticed, as we read this verse, regarding the rendering of the Greek in the English version. "Through Christ Jesus" should undoubtedly be "In Christ Jesus." "Through" was regarded doubtless as a paraphrase of the Greek preposition (ἐν) by the translators of the authorised version. But we are now reasonably sure as a matter of language that wherever the connection does not demand another rendering of that preposition we had better keep to its exact equivalent, "*in*." And here "in" is exactly in point. It is not merely "through" the Lord Jesus Christ as a channel, but "in" Him as an abode that the realization of this promise comes. Next we come to the words, "*keep* your hearts and minds." The words rendered "to keep" may be more literally and pictorially rendered "to garrison," "sentinel," or "safeguard." The idea is the faithful watcher of the castle gate who forbids unlawful intruders to enter: and for the words "hearts and *minds*" we had better read "*thoughts*." It is not the mind in the abstract which is meant, but its actions in detail. Not only in a large and general sense, but as regards all the restless detailed movements of the mind, the power of the peace of God shall act, shall calm, shall "safeguard." Again—"It *passeth all understanding*." Yes; mind may apprehend the fact, may recognise it, may study it so far as it can go, but it can never comprehend all its bright mystery. This "peace" has to do with the whole being, and the faculty of reason alone cannot account for its wonderful power. We further notice on the wording of the verse that it is a promise. In the immemorial benediction of the Church it is uttered as an authoritative prayer: "The peace of God keep your hearts and minds." The ministry of the Church, with the sanction of the Lord's promise behind it, so speaks to the faithful Christian, *invoking* the peace of God on him. But that benediction is taken from this passage, and this passage is an explicit *promise* that the peace of God *shall* keep your hearts and thoughts. One further word: let us notice the first syllable of the text: "*And* the peace of God." Here is a golden link in a golden chain. This promise does not stand apart; it is connected with what has gone before. The previous verses, from the fourth downwards, are other links of this chain of gold. The first bids us (ver. 4) "Rejoice in the Lord." The second (ver. 5) runs, "Let your moderation (or self-forgetting calmness of spirit) be known unto all men." Then comes text three: "The Lord is at hand"; the Lord is close at your side; let that fact with its calming and invigorating power sink into you. Then the fourth (ver. 6): "Be anxious for nothing, but in everything, with thanksgiving, let your requests be known unto God." Speak to the Invisible who listens. Speak to the Presence who lives. Speak to the mighty Archtype of your own personality; for He responds to you, having made you for Himself. Speak! It is not to the air, but to Him. Tell Him what you want. Live the life of converse with God. So the whole chain hangs together: Rejoicing in the Lord; overcoming self; remembering His presence; talking to Him as you go on your way; *so* the peace of God shall keep your hearts and thoughts. We have here promised in the Holy Scriptures a thing which the human heart in many ages has sought for with a wistful quest; a deep internal calm amid the disquiet of existence. It is familiar in the classical philosophies, this search for rest. And to go to our own times and the other side of the globe, I was reading, but the other day, the translation by my brother, the English Bishop in Mid-China, of a religious tract written purely from the pagan point of view; the whole subject of it was internal peace. The writer recommended to the human hearts around him, seeking like him for a quietism of feeling which shall be better than the friction of ordinary life, that they should seek first by discipline of the heart itself to calm and still it, and then to go beyond that into a further and inner sanctuary. "Cultivate the heart," said the strange words of this eastern mystic, a man of our own day, "but seek still further *the state of no-heart*." That is an internal insensibility, so to speak; a state in which circumstances should fall, as it were, on an impassive surface. The writer did not, I think, intend to recommend a seclusion in a desert or hermitage. It was among the busy things of life (one sentence said this distinctly) that he intended his quietist to live. The man might be a workman or an administrator or any thing else. "The myriad affairs of life" would surge around him. He would pass through them; yes—but they would not pass through him.

He would deal with them, but with a sort of automatic calm in his inner soul. It was a striking theory. But it was a very cold one, and introduced you into a very dark region. And I thus mention to you this pagan counterpart of the Divine reality given us in this verse, merely to remind you that there is such a thing, quite outside Christianity, as the quest of the human heart for that peace of mind which may still the heart and thoughts into something better than their ordinary agitation, disturbance, distraction, and unrest.

Now here we have this promised in the Christian Scriptures as the peace of God. The thoughtful Chinaman who wrote the tract I have been speaking of, theoretically could hardly speak of the peace of *God* at all; for his creed scarcely admits of the existence of a Personal Supreme. But the Holy Scriptures are full, quite full, of the Divine Personality, and the personal love of God. And my purpose this afternoon is to hold

up once more before myself and you this promise, as precisely this—the promise of a personal gift of Peace—the peace not of philosophy, but of God in Jesus Christ His Son; a peace not visionary, but a working power; a peace not only meant to act in pious moments, in the House of Prayer, or at the Sacred Table, but when we are out "*before the sons of men*" (Psal. xxxi., 21), and in the common day of the present time.

May I just remind you, then, of two illustrations given us in this same short letter we know as the Epistle to the Philippians? What a tiny thing that Epistle is! Yet what heights and depths of power and peace, of strength and rest, of present good and coming blessedness, does it not unfold! If our whole Bible were lost and only that preserved, you could almost construct a complete Christianity out of it. But one point in it (as in the whole Bible) is that although the Word of God, it is the writing of man. And its writer was a man whose circumstances when he wrote compelled him to say something of himself, and led him (perhaps all unconsciously) to tell us what *he* understood by the peace of God keeping our hearts and thoughts. In the first chapter you may remember there is a passage alluding to two extreme trials which were laid upon St. Paul personally. The one was a trial of exquisite personal vexation. The other was a trial of solemn suspense. He was a prisoner at Rome; after a life of activity he was compelled to live for two years within walls. There was a Mission Church in Rome, and, alas, the converts were by no means united. Many of them were in bitter opposition to St. Paul, and knowing that he was shut up they took a cruel advantage of the opportunity, to extend their influence and discredit his (see chap. i., 15, 16). Imagine the position. Was it not an exquisite trial, a fiery dart shot against the Apostle's soul? Will he not show signs of anger and disturbance, or, if you please, a righteous indignation at such—not merely error, but—unfairness? Nay, he will not; he is not angry. One great commentator, the late Bishop of Durham (Lightfoot), making for once, I think, a mistake, says (in his notes on Philippians) that St. Paul "crushes a feeling of personal annoyance." Crushing is an irritating process! And I do not see any signs of it in this passage. The man *escapes* his trouble, rather than crushes it, by the fact that the Master was the inward sentinel of his life. All he thinks of is Christ. "Christ is preached"; and it shall be a fresh occasion for "Christ to be magnified in my body." It is an opportunity for him not to fret and fume about himself, but to glorify his Master by a manifestation of His power over his spirit and his actions. Then, in the same tone, he goes on to speak of the second trial—the awful suspense that was on him. Was he to live, or to be put to death? Any day his execution might be announced; he might be summoned to follow the executioner to the block. Here was indeed a dilemma, a suspense. There is such a thing as a doubt in the human heart whether life is, or is not, worth living. But the dilemma in St. Paul's heart was of an opposite kind. There were mighty attractions for him on the right hand and on the left. Life was delightful, and death was delightful. He was in a state of pleasing suspense between two pleasures! Now what made this deep serenity possible? How could he say, "to me to live is Christ, and to die is gain?" It was that Jesus Christ had become all in all to him: "to him to live was—Christ." Life—the interest and occupation of it, if it was prolonged, would be Jesus Christ. And if they took him out and struck off his head it would be still—Jesus Christ; for "to depart is to be *with Christ*, which is better." "Better" than what? Observe this well. Not merely better than the *trials* of life, but better than the life which he describes as "*Christ.*" Yes, better than even this would it be to die and be with Him. It would be the same, only unboundedly better, because of the conditions of the enjoyment.

I have read to you my text and those illustrations of it for a very simple purpose. It is to remind you, on the one hand, that the promises of scripture have all of them passed, on their way to us, through the experience of human hearts. Thank God, the Bible did not drop from heaven, but was written by men on earth; there is not one page of it which, while being the oracle of God, is not the product of man. There is not a promise which has come to us except through a heart which had proved it; or a doctrine or truth which has come to us except through one to whom God had made it live with a life intensely real. Then for us these things are as possible as to the men who wrote them; what man has received, by grace, man can receive. And that brings us to the further thought of the practicality and the depths of the Christian promise. What can be more *secluded*, more *secret*, in religious thought than this perfect peace? True, but it is not meant to be folded in a napkin; it is to be worn as a helmet, and wielded as a sword. The wonderful thirty-first Psalm speaks of "the secret of the presence" in which the servant of God, who has "put his trust in Him before the sons of men," finds possible the life of rest. He need not seek that rest in the forests and the mountains, "in the dens and caves of the earth"; he has it amidst "the provoking of all men, and the strife of tongues." The peace of God, that is to say the presence of the God of peace, the presence known to us as the companionship of Christ, is a fact of human experience in the walks of real human life. It is a thing meant for wear and tear in such lives as your lives, which are not dreams, but lived among the sons of men. And the blessing of this rest is not only in what it does for the man in his own soul, in the growth and deepening of his own inner life, but in what it can do through the man for others whom he may touch. I am speaking primarily to Christian men, joined together in fellowship in a life so full of profoundest interest and noblest prospects as yours. And I lay it upon you for your own sakes to seek this sacred inner rest. But not for yourselves only is it to be sought. To all the world that moves around, so far as they can touch you and you them, this peace

of God in you may be of use for God. For the world's sake, and for our Master's sake, let us seek the deep peace in Him; a heart which is at leisure from itself, because Christ has taken charge of it is the heart to deal sympathetically with others, to understand the mind of each it comes into contact with, and to convey to them the Master's message. We always have an influence proportionate to what *we are*. We shall work for God all the better as we are possessed by the peace of God. Let the life be as wide as possible in circumference, but let the centre move true upon its bearings, which never alter.

With great humility, I would leave with you this message of my Master's word. It points us straight to Him whom we know; and how many of us could with special gladness testify that we know Christ as the fact of facts, the reality behind all the appearances of this world! With Christ we know it is possible to walk through the loudest and busiest scenes, through the most distracted times; the Divine Companion can go with us and shield us with His presence. Our text points us straight to Him. It animates us to say to others, come with us, for—not we, but—our Lord will do you good. He will not stunt and shrivel your life; He will develope and enrich it. But you must come to His feet; you must come to His heart; you must put your hands betwixt His as the trusted Lord and rightful Despot of your being. And then you shall know that the peace of God is not a shadow, not a mirage of the desert, but the pool of living water and the rock of eternal rest; and, resting there yourself, you shall also in another respect ever be moving on, working, serving, loving, and leaving around and behind you a track of blessing. Mary Magdalene (we read it just now in the Lesson) went out of the Garden knowing that she had seen the Lord; and the first thing she did was to go and let others know. So she set the first spark to the kindling flame of the blessed Gospel of the Resurrection.

So be it. The *peace of God* keep our hearts and minds, and then we shall manifest the greatness of it, we shall diffuse the blissfulness of it, to the end of our pilgrimage, when "the life which is Christ" shall be changed for the "departing and being with Christ, *which is far better*."

Chapel News.

Contributed by the Chaplain.

The offertory at the Harvest Festival on October 6th amounted to £3 19s. 1d., and will be given to Foreign Missions.

The Communion Service for November will be sung to Redhead in D, the Magnificat and Nunc Dimittis to Gadsby in D.

On Sunday, November 24th, the cause of the St. Andrew's Waterside Mission will be before us. Sermons will be preached and offertories collected for it.

The chief feature of the arrangements for Advent will be a Three Days' Devotion for Nurses on December 9th, 10th and 11th, conducted by Canon Lester, Rector of Lexden, Colchester, and late Diocesan Missioner for Lichfield. The usual "Special Tuesday Services" will not, therefore, be held this Advent. The programme for the three days is not yet quite settled, but it should be clearly understood that the ordinary routine of the Hospital will not be interrupted or disarranged in the slightest degree.

Pass List.

Second Conjoint Examination, October, 1895.

(Under Regulations dated January 1st, 1892.)

Barrow, H. P. W.
Cazenove, W. R.
Fox, H. W.
Harrison, W. W.
Howells, J.
Lewis, A. D.
Pritchard, R. J.
Turner, H. S.
Watson, C. F.
Williams, N.

First Conjoint Examination.

Chemistry.

Cawston, A. E.
Goble, E. W.
Hall, R. W. B.
Lewis, A. C.
Loosely, W. H.

Elementary Biology.

Brangwin, C. H.
Bryan, C. A. D.
Davies, A. G. C.
Morris, H. E.

Elementary Anatomy.

Graves, D. S.
Lister-Kaye, A.
Hicks, C. E.

Second Conjoint Examination, October, 1895.

(Under the Four Years' Regulations.)

Anatomy and Physiology.

Davies, E. C.
Rae, F. L.
Musgrove, E. H.

Anatomy only.

Ashby, E.
Penrose, A. W.

Physiology only.

Fryer, E.
Passmore, A. B.

First Conjoint Examination.

Chemistry.

Edwards, W. H.

Materia Medica and Pharmacy.

Duncan, G. E.
Mussellwhite, W.
Edwards, W. H.

Correspondence.

To the Editor of Guy's Hospital Gazette.

In the "Charity."

Dear Sir,—The case of "Difficult Labour" (No. 1) in the last Guy's Gazette is of great interest. No commentary follows the report of the case as to the nature of the difficulty. No description of this great difficulty (probably on account of its rarity) is given in any of the English obstetrical class-books.

At the meeting of the International Congress in 1881, I presented a paper on "Trismus and Tetanus of the Uterus in Labour." The case recorded in the Gazette so closely resembled those of my own, that I think it belongs to the same class. I send for your acceptance a copy of my paper.—Yours very truly,

Oct. 17th, 1895. GEORGE ROPER, M.D.,
Oulton Lodge, Aylsham, Norfolk.

[An abstract of Dr. Roper's paper is published on pages 411–412 under In the "Charity."—Ed. G.H.G.]

In the "Charity."

Sir,—The first case—that of transverse presentation—published in your paper of October 12th brings to my mind a similar case which occurred in my practice two years ago, and which, if you think it worth while, you can publish. A little woman, after being in pain for two days off and on, was taken with severe pain early one morning, and at 9 a.m. the waters broke and something came down; but owing to an unusual degree of ignorant modesty she would not let a neighbour look what was amiss, nor send for a doctor until late in the afternoon, when the left arm was protruded and swollen, the fœtus firmly fixed in the pelvis—head to right hip. Under chloroform I found it impossible to turn, and having no decapitating hook I managed to include the neck of the fœtus between two fingers of my left hand, and with a pair of long uterine scissors slowly, and with great perseverance and difficulty, divided the neck close to the shoulders and readily delivered the trunk, but found more difficulty with the head; after pulling it well down with the blunt hook, applied forceps and extracted. After delivery I found a rent on the right side of the vagina, separating its connection with the uterus, where the great pressure of the head had lain; this was treated by careful irrigating with warm boric lotion, keeping patient entirely on her left side, and taking care to provide free egress for the fluid with two fingers of left hand in vagina. Notwithstanding some septic symptoms, which required the uterus to be washed out with a celluloid tube several times, the woman recovered, with the os uteri adherent to vagina.—Yours truly,

Melbourne, Derby. W. M. KNIPE.

"Our Profession, Our Patients, Our Public, and Our Press."

Dear Sir,—I much regret that I was unable to be present at the first meeting of the Physical Society, to hear Mr. George De'Ath's most excellent paper. While agreeing with him on most points in the paper taken as a whole, I must make an exception to one or two statements, which I cannot let pass without comment.

A propos of hospital training, and men leaving hospital to go into practice, Mr. George De'Ath says: "Men who have, therefore, to deal with patients, or the public, that is to say, start in practice, are lost to some extent, have no power (because they have not the knowledge which is power) to conduct a case, know not how to treat their patients or their patients' friends, cannot even behave themselves in a sick-room." Now, I take it that this is a very low estimate indeed, and not a proper one to take of men who have finished or are about to finish their curriculum at Guy's. It reflects upon their characters as gentlemen and their ability as medical men, and to some extent upon their teachers for not affording them a better training. That the above description may apply to a few men is very probable, considering the number of students who leave Guy's to start in practice, but that it applies to anything more than a very small fraction of their number I cannot believe.

Later on the following occurs: "We should be as men treating other men, not as hopitalised beings treating patients. In all our relationships we should remember that kindness, gentleness, and sympathy add to the true value of skill, and that though the powers of the head are great, the powers of the heart are greater."

Now, I maintain that patients treated at Guy's are treated as men, and by men, in the shape of members of the Staff and students generally, and that kindness, gentleness, and sympathy are not lacking in them. Sympathy is all very well in its way, but it is not the chief end and aim of the doctor, and, in my experience of private practice, I find that there is a great tendency for the general practitioner to let sympathy take the place of physical diagnosis to the detriment of the patient's health; thus, within the last six months, I have met with two patients in each of whom there was a large pleuritic effusion (verified by subsequent aspiration) which had been entirely overlooked by the ultra-sympathetic practitioner.—Yours truly,

W. J. JOHNSON.

Students' Glee Club.

Dear Sir,—I was very interested to see in my Gazette this week that the Nurses had formed a Choral Society. When I was a student we used to have a very good Glee Club, but it died a natural death when the leader was transferred to private practice; and I understand that one or two similar undertakings since my time have

suffered a similar fate. The Glee Club that I remember afforded, while it lasted, so much pleasure both to the performers and to those who from time to time attended the concerts they got up, that one cannot but wish that some more permanent musical association could be formed. There always seems to be some talent among Guy's men, if one may judge from the activity reported in your columns on the part of what are, I think, called the "Dis-Guysed Minstrels" at Christmas-time.

Now, Sir, I come to the point of my letter, which is to suggest that if there are any musicians about now they should take a leaf out of the Nurses' book and enrol themselves under a paid conductor. This would give a fair prospect of permanence to the Glee Club, and would certainly add to the pleasure of the members and those who were fortunate enough to listen to their performances. Perhaps the services of the conductor of the Nurses' Society could be also secured for the men's club, and arrangements made for occasional conjoined performances.—I am, yours obediently, E.

Why Men are not Keen on Playing Football.

Dear Sir,—Your correspondent "Fair Play" evidently has a grievance, though it is a pity that he is not better able to express it. Perhaps he only wanted an opportunity for abusing the selection committee, and, if so, he has made good use of it. But surely a man who signs himself "Fair Play" ought, before rushing into print, to find out whether his statements are accurate and whether the accusations he makes are fair, and this he could have done with very little trouble.

Apparently he is surprised at the few freshmen who were down to play in the first match of the season, though he merely remarks that his surprise is caused by their number, and not whether the magnitude or the smallness of that number caused it. Then he wants "one or two new men to be given a trial, and if the team are short to have it filled up by regular players from the second." Three freshmen and five of last year's second played in the match in question. Does he want more freshmen to have played? If so, why does he next ask "what combination is there amongst the new men down to play?" If there is none among three, what would there be among, let us say, six? His remarks about new men being tried for the first XV., if straight from school or college, regardless of what team they played in there, is quite pointless. If a man is thought to be worth trying, he is tried; and the first thing the committee ask of a freshman is what teams he has played for, and his answer will materially affect which team he is tried in here. As to men being tried for the first and then not given a place in the second, of which he says he can point out several instances, I am afraid he is in this matter as inaccurate as in others. A man may be "chucked" from the second for one match, if he thinks he is too good to play for it, and such a case is not unknown, but it is only done to bring him to his senses, and is not permanent.

Many freshmen will not play keenly in second matches, and so can hardly wonder if they lose their place in that team, although they may have played for the first; they fail to see that a reputation is not, or ought not to be, a sufficient qualification to enable them to gain a place in a football team.

His promiscuous abuse of the committee is in very bad taste, and not at all deserved by men who have a very difficult task set them. Apologising for the length of this letter,—I am, &c.,

VERITAS.

A Chess Club.

Dear Sir,—I was very glad to see in your last issue the idea projected of the formation of a Chess Club at Guy's. As far as I know, no other hospital as yet possesses a club of this nature, and in this—as in all other things—Guy's ought certainly to "play the first move." There is no reason why Inter-Hospital championships should not be arranged and matches played in regular sequence against other clubs. Personally, I think the existence of a club would meet two long-felt needs:—not knowing what men are players, and want of regular practice in the game. Thus another wheel-within-wheel of social intercourse would be set going, and, I venture to hope, the Clubs' Union would be enlarged by the addition of another constituent.

Already I have said too much, but trusting there will be some definite outcome of this correspondence, and willing to become a member of any club formed,—I am, yours truly,

"CHECK-MATE."

Nursing Staff Choral Society.

OUR FIRST PRACTICE.

Eight o'clock on the evening of October 11th found quite a large and expectant company of sisters and nurses assembled in the Matron's drawing-room at the Home, awaiting the arrival of the conductor of the newly-organised "Choral Society."

Those of us nurses who, by means of the silver key, had passed the portals of the Society, and become members, had done our best to finish our ward-work by a quarter to eight on that particular evening, for on such an occasion as this we had no difficulty in obtaining leave of absence from our ward sisters until nine o'clock.

A certain air of subdued excitement characterised the assembly, not altogether unmixed with some nervousness; for there were timid souls among us who were quaking with fear lest they should be called upon to sing alone in that terrible ordeal known as "having one's voice tried." Therefore, eager heads looked towards the door as each new arrival appeared, and a quiver of undisguised interest ran through everyone as, punctually

at eight o'clock, our conductor, Mr. Taylor, was announced.

We soon decided, however, that he was not a person to be dreaded, but that, on the contrary, he was possessed of most easy, reassuring manners, and was evidently gifted with great persuasive powers, and a large sense of humour.

The lesson that first evening resolved itself more into a kind of preliminary lecture on singing and the management of the voice generally, mingled with certain information upon "sound-waves," etc., which to my unscientific ear, seemed to savour of a page from a work on "Physics," and made us feel we were soon going to become very learned indeed.

We were told that the Choral Society is quite a pioneer movement among the hospitals, and that, as it is at present the only one in existence, we are all bound to work most earnestly to make it a success. After the singing of a scale or two, some common errors were pointed out to us in such a way as to cause a continual ripple of merriment through the class, though, at the same time, stimulating us to the utmost to do better next time.

There was the "slip-shod" or lazy method of singing, where the performer slurs from one note to another, making none clear and distinct. There was the "gasping" way of catching one's breath, instead of taking deep, full inspirations, the "monotonous" way of giving the same amount of expression to each note, and many other usual "drawing-room faults," which, as our conductor observed, we might hear for ourselves any day, and be quite certain that though the company present might applaud the singer, and say what a charming song it was, yet they would be very glad when it was done.

We were then shown the "more excellent way," and told how to avoid the by-paths of nasal, harsh and unmelodious singing.

There was a rough division of the class into sopranos and altos, in which the balance was decidedly on the side of the sopranos, partly, perhaps, on account of the feeling some of us had that there was safety in number s and that, therefore, we had better go over to the majority.

The lecture concluded with the assurance that we should begin to work in earnest at the next meeting, and the injunction to practise the singing of the scales through the week whenever and wherever we could without hindrance to our work, or becoming actively unpopular with our neighbours.

A cup of tea—that ever-welcome beverage of the nurse—provided by the kindness of the Matron, brought the proceedings to a close, and we returned to our wards having thoroughly enjoyed the first practice, and feeling that the Choral Society was going to be a great success; also, that we were very glad we had become members.

Indeed, we are inclined to think that societies in connection with Guy's always are a success, and with Mrs. Pye-Smith as president, Mrs. Shaw for treasurer, and our Matron for secretary, we see no reason why the Choral Society should be any exception to the general rule.

Our best thanks are due to everyone who has helped to organise this new scheme, which bids fair to brighten the coming winter months with an ever-fresh source of interest and amusement.

A MEMBER.

Appointments.

Clerks to the Anæsthetists.—Messrs. J. J. Foster, J. Howell, N. H. Pike, W. E. Plummer, T. W. Stanton, S. Whicher.

Externs.—Messrs. C. W. Booker, C. G. Burton, G. E. Duncan, A. T. Falwasser, H. T. Hicks.

Dental Appointments.

THE following appointments have been recommended by the Dental Council and approved by the Treasurer:—

Dental House-Surgeon (for three months only).—Mr. A. J. Collett.

Assistant Dental House-Surgeon (for three months only).—Mr. H. D. Mathews.

Curator of the Dental Laboratory.—Mr. J. M. C. Jacobs.

From the Gazette's Special Pathologist.

NOTICES.

J. M. O., FISHGUARD.—Microscopic examination of the membrane showed the presence of numerous cocci, leptothrix, and a long thick bacillus. After 24 hours' incubation on blood serum, a few fair-sized, raised, spherical, whitish colonies had made their appearance. Microscopically these consisted of Klebs-Löffler bacilli, with a large admixture of staphylococci, and a bacillus occurring in long threads.

J. R. B., SUTTON.—Sections of the tumour show an ulcerated surface, and much inflammatory thickening of the tissue beneath. The adjacent mucous membrane is thickened. There is no evidence of malignant disease.

G. M. J., ALTON.—The tumour is a well-defined and, apparently, encapsulated fibro-adenoma of the breast.

S. W. M., SOUTH PETHERTON.—Tubercle bacilli are present in the sputum.

A. C. Z., LEAMINGTON.—After twenty-four hours' incubation on blood serum, a few small, spherical, whitish colonies had made their appearance. Microscopically these consisted of Klebs-Löffler Bacilli in pure culture.

W. G., SALISBURY.—The tumour consists of fibro-muscular basis in which are embedded many rounded spaces lined with columnar epithelium and filled with mucoid contents. It has no appearance of being malignant; its structure resembles that of a cystic polypus of the os uteri.

W. R., MAIDEN NEWTON.—The growth is composed of glandular tissue embedded in an abundant and cellular stroma. Formerly this kind of tumour was called an adeno-sarcoma, but they are now regarded as soft fibro-adenomata of an innocent nature.

J. P. P., ORMSKIRK.—There is no appearance of malignant disease in this specimen. A microscopic section shows merely granulation material and developing fibrous tissue.

PATHOLOGIST.

Sport.

Association Football.

GUY'S v. WEYBRIDGE.

Played at Weybridge on Saturday, October 12th. It was rather unfortunate that the opening match of the season should be against this powerful club, who are holders of the Surrey Cup, and include in their ranks several County men, with two or three 'Varsity Blues. We were only able to take down a very moderate eleven, in which were but four of last year's Cup team.

Fitz-Hugh, after losing the toss, kicked off against wind and sun, and it was soon evident that the game would be fast and exciting. Our defence, being extremely weak, was soon hard pressed, and ten minutes from the start, Weybridge opened their account, but Fitz-Hugh equalised almost immediately, the play being very interesting for the rest of the first half, when the score stood three goals all. The first twenty-five minutes of the second half were a repetition, the score at the end of this time being four goals each. Then came a most disastrous twenty minutes for us; want of condition began to tell its tale in our ranks, and Weybridge very quickly put on four more goals, and so ran out victorious by 8 to 4. This score in no way represents the game, as two goals might, apparently, have been stopped, and another was palpably offside; our forwards, too, lost some good opportunities through erratic shooting. Fitz-Hugh, Mandy and Walker were most conspicuous for us, the latter worked extremely hard and was the mainstay of the back division, while the two former played very well, and both brought off some brilliant runs. Ford is likely to prove a useful forward when he has learnt to make off with the ball as soon as he receives it, and to look where he is passing. Barker stopped some good shots, but appeared to give an unnecessary number of corners—a rather serious fault, since the opposing team is sure to score from one or two of them, as indeed happened in this match. Team:—

Guy's.—H. M. S. Barker (goal); H. Hewetson and E. A. Longhurst (backs); R. W. Hall, F. E. Walker and M. H. Thornely (halves); P. S. Mandy, A. Pearson, R. T. Fitz-Hugh, W. Ford, L. Humphrey (forwards).

GUY'S A. v. WEYBRIDGE 2nd.

Played at Weybridge on Thursday, October 17th. The Guy's team was rather stronger than the usual 2nd XI., and it was unfortunate that the result was not in our favour. During the first half we did most of the pressing and it seemed likely that we should win. By means of some good combination among the forwards, a goal was scored for us by Mandy. The whole team was very well together, and some good passing and runs down the field were shown; the defence also was better than usual.

After changing ends, Weybridge pressed strongly, and our halves and backs had a lot to do. Several hot shots were put in by the Weybridge forwards, which Thomas saved brilliantly. The fast pace of the game, however, now began to tell on our men, and our combination died away. Weybridge scored twice in succession, and obtained a third point shortly before the close of the game, which thus ended in their favour by 3 goals to 1. Team:—

Guy's.—A. R. Thomas (goal); G. Marshall and W. Smith (backs); H. A. Higgens, H. Lloyd Driver and B. Hall (captain) (halves); L. Humphrey, G. Ford, A. Pearson, H. Kirk and P. S. Mandy (forwards).

GUY'S v. OLD WILSONIANS.

Played at Honor Oak Park on Saturday, October 19th, the result being a draw of three goals each. Ill-luck seems to cling to us; to add to our other misfortunes, we had to enter the field without the aid of our captain, Fitz-Hugh, who also is now on the injured list, and will not be able to play for some time, so that our team, instead of getting stronger as the season advances, is getting weaker. The game scarcely needs any description, being of an uninteresting and scrambling nature, without any signs of combination, except for a few minutes in the second half. At half-time the Old Boys led by 2—0.

On the re-start, our men put considerably more life into the game, and ten minutes from time led by 3—2, chiefly owing to some fine centres by Humphrey, but the Old Boys managed to draw level again just before the end.

Humphrey, Walker and Barker were the pick, and it was mainly owing to their efforts that we made such a good fight. Team:—

Guy's.—H. M. S. Barker (goal); W. Marshall and E. A. Longhurst (backs); H. Hall, F. E. Walker and M. H. Thornely (halves); P. S. Mandy, F. V. Kirk, W. G. Palmer, W. Ford, and L. Humphrey (forwards).

Since writing the above, I hear that our genial secretary, H. Bernard Onraët, is in one of the wards suffering from an attack of pleurisy. I am sure all members of the team wish him a speedy recovery.

Rugby Football.

LEICESTER v. GUY'S HOSPITAL.

From the *Leicester Daily Mercury*, of Saturday, Oct. 19th.

The matches played on the Welford Road ground between Leicester and the London Hospital teams have become very popular with the home crowd, and it is something in favour of the Tigers to find that the medicos are always willing to renew their fixtures from year to year, although they have rarely achieved a win. Last season Leicester were victorious in all three matches, St. Bart.'s proving the strongest of their opponents, and St. Thomas's the weakest. The Guy's Hospital fifteen, who were entertained by Leicester to-day, have not distinguished themselves very highly in the present season, having suffered defeat on the previous Wednesday at the hands of Cambridge University, by 2 goals 6 tries to

nothing, while last Saturday a combined St. Thomas's and Guy's team were beaten by Blackheath by 2 goals 3 tries to 1 goal 1 try. With the exception of the popular captain, E. Redman, who, though better, did not consider himself in form, Leicester had their full strength, A. O. Jones, F. A. Jackson, H. J. Simpson, and M. E. Whitehead resuming their places in the team, while the famous forward, W. Yiend made his first appearance in Leicester colours. The players were as follows:—

LEICESTER.—A. O. Jones (back); A. Field, R. Hesmondhalgh, F. A. Jackson, and A. W. Woodyatt (three-quarter backs); W. J. Foreman (captain) and H. J. Simpson (half-backs); Dr. Nicholson, W. Yiend, R. P. Swain, W. Jackson, G. Jones, A. E. Cooke, R. N. Campbell, and M. E. Whitehead (forwards).

GUY'S.—C. E. Michael (back); F. L. Rae, A. Kinsey-Morgan, A. C. Ransford, and F. Sime (three-quarter backs); J. N. Gardiner, and R. S. Thorpe (half-backs); W. Tyson, E. G. Goddard, P. A. Dykes, P. D. Hunter, W. P. Gwynn, H. V. Bagshaw, A. Gibson, and M. D. Wood (forwards).

Referee: Mr. A. R. Badger, Old Edwardians.

The weather was dull and cloudy, but fortunately dry, and the ground to all appearances was in good condition. Scarcely a breath of wind prevailed when the start was made, the visitors kicking off from the Welford Road end. A. O. Jones returned into touch just beyond the twenty-five mark, where the first scrimmage ensued. Simpson passed out to Foreman, who in turn, transferred to Field, and a beautiful bit of handling was then seen, in which Yiend, Woodyatt and F. A. Jackson took part, the latter carrying the ball well into his opponents' twenty-five before he was forced into touch. Getting the better of some loose play, Guy's quickly took the ball back into the home half, where a number of hard fought scrums took place. A nice punt and follow-up by F. A. Jackson caused the venue to be changed, and the Leicester backs then indulged in some passing, which was spoiled by Field being out of his place. Not to be denied, the home backs made another attempt to break through, Simpson, Foreman, Woodyatt and Jackson all participating in some pretty handling work, but the last-named was again thrown into touch by Rae. Leicester were then penalised for an infringement by Foreman, and the free kick took the game back into the home quarter. One of the visiting half-backs got possession from a scrum, and made a futile drop at goal, the ball travelling dead. After some even play in mid-field, the visiting backs displayed excellent form in the passing game, a smart round ending in Syme receiving the ball and racing down the left wing in fine style. He was eventually held by Woodyatt and Jones, but not before the Tiger's goal line was seriously endangered. Then, for playing offside, Guy's were penalised, and by means of the free, Leicester relieved to mid-field, and a pass by Yiend to Field resulted in further ground being gained. Opportunities were lost to the home side through Woodyatt and Field failing to take really good passes, and Hesmondhalgh was guilty of the same fault when Simpson, after running strongly from the scrum, passed him the ball at the twenty-five line. A plucky dash from the line-out by Woodyatt caused the visitors' quarters to be invaded, and a punt from one of the home forwards caused the visitors to retire to the vicinity of their own goal line. Determined efforts were made here by the Tigers to cross the Hospital goal line, Simpson, Yiend, and George Jones being prominent in a strong rush, which resulted in Michael being held almost under the posts. From the scrimmage here the visitors passed out, and the ball was kicked down to A. O. Jones, who took a careful drop at goal, the ball, unfortunately, travelling wide, and going dead. Guy's played offside with the drop out, and the game settled down in their twenty-five. After several ineffective attempts to break through the visitors' defence, the Tigers were at length successful, Foreman picking up behind the scrum, and dodging beautifully through the opposing backs, scored by himself behind the posts. From an easy position Field had no difficulty in placing a goal. After this the visitors made strenuous efforts to get on equal terms, but their back play was very faulty, and Ransford, who had the ball passed to him in mid-field, failing to gather it properly, and F. A. Jackson, rushing up, cleverly secured it, and made tracks for the visitors' line. He had half the length of the field to run, but in spite of the distance he managed to reach the Hospital line before he was pulled down. Apparently he grounded the ball for a try, but then lost possession, and Ted Cooke, dashing up, made certain of the point by falling on the ball. From rather a difficult position, Cooke failed at goal. Leicester were soon pressing again, a splendid kick by Geo. Jones driving the doctors close back on their goal-line. They managed to relieve the pressure somewhat, but from a scrimmage near the twenty-five line Foreman stole away with the ball, and scored a pretty try near the corner flag. This time the ball was placed for Yiend, but the angle proved too difficult for him. After another two or three minutes' play, the whistle sounded for half-time, the score then being— LEICESTER, 1 goal 2 tries.

GUY'S, nil.

Resuming, Leicester soon took up the attack, and play was for some time confined to the visitors' twenty-five. Foreman made a gallant attempt to break through from a scrum, and was only held about a couple of yards from the line. Just afterwards Simpson had also hard lines in not scoring, after taking a smart pass from Foreman, and slipping when a clear course seemed open to him. A long touch-kick by Rae brought the Hospital much-needed relief, but it was not long before Leicester were on the aggressive again, their three-quarter line showing improved form in the passing game. Some long kicks were exchanged between Jones and Rae, and then a tricky bit of play between Simpson and Foreman enabled Leicester to make an incursion into Hospital territory. Woodyatt made his mark, and the kick was well followed up by Nicholson, who only just failed to get possession of the ball. A

moment later the leather was kicked dead. With the drop-out the visitors played up strongly, and were very smart on the ball, but in the scrimmages they were well beaten by the Leicester forwards. Field was conspicuous with a fine tackle, and a nice bit of handling between Simpson, Foreman and Field gained considerable ground, while a splendid dribble by Swain and a high punt by F. A. Jackson drove the visitors still further back. With the home scrimmagers mostly commanding the ball, the backs had plenty of opportunities given them, but their passing, though showing an improvement on recent form, was by no means up to the mark. A dribble by Field took the ball close to the Hospital corner flag, and the home forwards rushed it over, but Michael just managed to save. Following the drop-out, Gardiner and Ransford made another strong effort, and some determined work on the part of their forwards took the leather down to A. O. Jones, who, however, proved quite equal to the occasion, and was very hard to pull down. In some scrambling play which ensued, Leicester held the advantage, and from a loose scrum Foreman got away and scored behind the posts, Jones converting to the major point. Guy's, after the re-start, rushed the ball into touch in the home twenty-five, and looked for an instant like scoring, but the ball was again brought back into Guy's territory, and Jackson got in near the touch-line; the kick failed, and even play brought the game to a close in favour of the Tigers by 2 goals 3 tries to nil.

Remarks "by a Looker-on."

Of the various sections the forwards — though not perfect—were the least to blame for the defeat of Guy's. They got the ball perhaps as frequently as their opponents, but were slow in getting rid of it, and seemed to be unable to wheel when occasion offered. In the loose they kicked too hard, though their tackling was always sure, hard and low; indeed, they clearly demonstrated the stupidity of other players in grabbing at an opponent's head and neck. Dykes, Goddard and Hunter showed up most, but Tyson and Gibson worked hard throughout. Our halves — though Gardiner improved considerably towards the close—contrasted feebly with a very smart pair of opponents, did good things at times, but generally seemed slow and wanting in cleverness, letting the enemy through again and again, which errors set the three-quarters a practically impossible task of stopping six people, at least, between them. Rae and Syme ran and kicked well, but Ransford alone showed any certainty in tackling, the others at times either missing their men entirely or going too high.

We trust that time and the presence of several absent members of the team will minimise these faults which, perhaps, by comparison, seemed especially evident.

GUY'S 2nd XV. v. LENNOX.

Tyson kicked off, the ball going behind. On the kick-out, good passing by the Guy's backs brought the ball into touch in the Lennox twenty-five, and Gwynn, getting the ball out of touch, passed to Gardiner, who ran between the posts. Gwynn converted. After the kick-off, some good passing by all the three-quarters ended in Syme getting a try close to the corner flag, after a good run. From a scrum on the twenty-five line, Gardiner got the ball and passed to Kinsey-Morgan who scored. Gwynn converted. After the kick off, some good passing ended in Kinsey-Morgan scoring again; this was unconverted, and from some loose play immediately after the kick-off, Syme picking up smartly, scored again. Gwynn converted.

Half-time. After the kick-off we pressed at once and nearly scored, but eventually lost a lot of ground through a futile drop at goal by Thorpe. Lennox now pressed for the first time, but a dribble headed by Bagshawe relieved, but not for long; Lennox again pressed, but Gwynn relieved with a good dribble, and by some good passing between Kinsey-Morgan, Gardiner and Bagshawe, the latter, after a good run, scored a try. After the kick-off a lot of scrambling play, in which Lennox had rather the best of matters, ended in Gardiner getting the ball and scoring, after a good run. The try was unconverted and the game ended, Guy's being victorious by 4 goals and 3 tries to nil.

Of the three-quarters, Kinsey-Morgan and Syme played very well. Walling at full-back only touched the ball on one occasion. Among the forwards, Bagshawe and Gibson played very well. Team:—

Guy's.—H. Walling (back); F. Syme, Kinsey-Morgan, A. C. Ransford, F. D. Jackson (three-quarter backs); R. S. Thorpe, J. N. Gardiner (half-backs); W. Tyson (captain), W. P. Gwynn, H. V. Bagshawe, R. Gibson, E. Cohen, M. D. Wood, H. M. Saward, W. Rashleigh (forwards). Referee: Mr. Hamblin-Smith.

3rd XV. v. UPPER CLAPTON 3rd.

This match was played on October 5th, at Tottenham, and resulted in a win for Guy's by one goal to nil.

A steady rain made the ball very greasy, and rendered accurate passing impossible, but our forwards used their feet well, and got most of the game. In the first half, Gaitskill scored a try, which Cleveland converted, and this proved the only score of the game. F. E. Walker and Harris were the best of our backs, and Mottram, Williams and Row, of the forwards. Team:—

Guy's.—J. B. Brockwell (back); Harris, Gaitskill, Walling and Barrow (three-quarters); F. E. Walker and Kinsey-Morgan (halves); Cleveland, Mottram, Walker, Row, Williams, Spriggs, Bignold and Featherstone (forwards).

3rd XV. v. STREATHAM 3rd.

This match was played at Honor Oak Park on October 19th, and resulted in an easy win for Guy's by six goals and one try (32 points) to nil. Tries by Clarke, Bignold, Bryant, Cleveland, Dad and Rock. Pike also dropped a very pretty goal. Our opponents, who played short, were completely out-played, as the score shows. Team:—

Guy's.—Muriel (back); W. T. Clarke, A. C. Rock, Manson and Brockwell (three-quarters); N. H. Pike and J. H. Bryant (halves); A. J. Cleveland, H. H. Bignold, T. M. Walker, F. J. Steward, Ousely, J. Dad, E. I. Spriggs and E. J. Evans (forwards).

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

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Guy's Hospital Gazette.

NOVEMBER 9, 1895.

Hare-lip.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

ONE of the earliest operations which you will have to perform in private practice will very likely be that for the cure of hare-lip. The accounts of this operation in most of our books are not easy to understand, and when you see the operation done in the theatre, you are so far off that many of the smaller details escape your observation. It seems a simple procedure to pare the edges and bring them together with sutures. But unless you attend to many small details in the operation and after treatment, you will find that your operation will fail, or that the union you obtain is faulty. I propose, therefore, to-day, after saying a few words upon the causation of hare-lip, to describe to you the method of operation, and subsequent treatment, which I have found most successful.

Causation of hare-lip.—As you all know, the upper part of the face is developed from three processes. The central, or *fronto-nasal*, process forms the nose, the middle part of the upper lip, and the middle of the upper alveolar process. The other two, the *maxillary* processes, form the cheeks and the side portions of the alveolar border. These processes should unite before the end of the third month of fœtal life. If this union fails completely, we have the worst cases of double hare-lip and cleft palate. If it fails only partially, the want of union may be (*a*) superficial, and produce single or double hare-lip; or (*b*) deep, and give rise to some form of cleft palate. A very few instances of hare-lip in the middle line have been observed, either from a separation of the lower end of the fronto-nasal process into two parts, or from its absence. Usually the hare-lip is on one side of the middle line, close to the line of junction of the pre-maxilla and maxillary processes. If I ask men where this is, the answer generally is, "the interval between the lateral incisor and the canine tooth." This is not quite correct, because sometimes in cases of hare-lip it is found that the lateral incisor is attached to the pre-maxillary bone; at other times to the maxillary portion; and in some cases there are two small lateral incisors, one being attached to the pre-maxillary and the other to the maxillary portion. The best answer, therefore, to this question is that the line of junction is between the median incisor and the canine tooth.

Next we may consider, why should there be an arrest of development? In many cases, no cause can be ascertained. In a few, maternal impression from mere fright is assigned as a cause. To be efficient the shock must have taken place during the first three months of pregnancy. In a few cases hereditary tendency plays an important part. For instance, in a case upon which I operated a short time ago, the uncle and great uncle of the patient had suffered from hare-lip. In other cases you will find that some illness has impaired the nutrition of the mother during the earlier part of gestation.

I shall now describe in detail to you the operation which I have found the best to remedy this deformity.

First, as to the best time for performing the operation. This depends to some extent on the severity of the deformity. I think it is

best to wait until the child is at least six weeks old; because by then the child is stronger to undergo the operation, and the mother is in a better condition to look after it. If you operate on a very young baby the prolabium is often so difficult to distinguish, and the parts are so small, that you may fail to get an accurate adjustment. In severe cases I usually wait still longer, until the child is from two to three months old.

The points which you should aim at in performing the operation are the following:—

1. *Good union.*—In order to obtain good union, the surfaces must be clean cut; they must be brought into good apposition, and kept in this position at as low a tension as possible. Further, the parts must be well supplied with blood and kept quite quiet.

2. You should avoid a notch in the lower border of the lip, such as often follows the contraction of the line of union.

3. Carefully adjust the prolabium.

4. Take care to form a proper floor to the nostril.

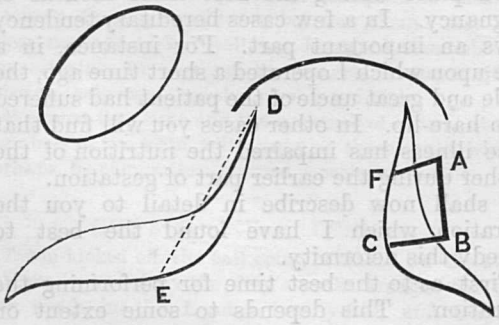
5. Avoid a vertical groove in the lip. This is often caused by paring away so little tissue that the muscular portions of the lip are not brought into contact.

6. Avoid an ugly scar, such as may follow any sloughing or ulceration caused by your stitches.

The patient having been anæsthetised, the steps of the operation are as follows:—

I. Divide attachment of cheek on maxillary side of cleft, and separate it freely from the bone with raspatory as far as the infra-orbital foramen.

II. Transfix lip on maxillary side, introducing knife a considerable distance from the margin of the cleft and carrying it somewhat obliquely through, so as to remove more skin than mucous membrane. The incision A B should extend from close to the ala of the nose as far as the prolabium, then directly inwards so as to form a small flap, B C, from the red part of the lip as it cuts its way out.



III. Make an incision, D E, through three-quarters of the thickness of the premaxillary portion, near to its margin, but do not divide the mucous membrane behind. In this way a portion of the paring may be used so as to get a broad raw surface. The hæmorrhage should be stopped by gentle pressure.

IV. With a pair of scissors trim the paring on the maxillary side, leaving a small flap, A F, to form the floor of the nostril. Also trim the paring on the premaxillary side, so that the whole of the raw surface formed by the three-quarters of the thickness of the lip and the turned back paring shall correspond in size with that upon the maxillary side.

Generally also it is necessary with the knife or scissors to extend the raw surface a short distance upwards upon the septum nasi, to provide an attachment for the small nasal flap A D.

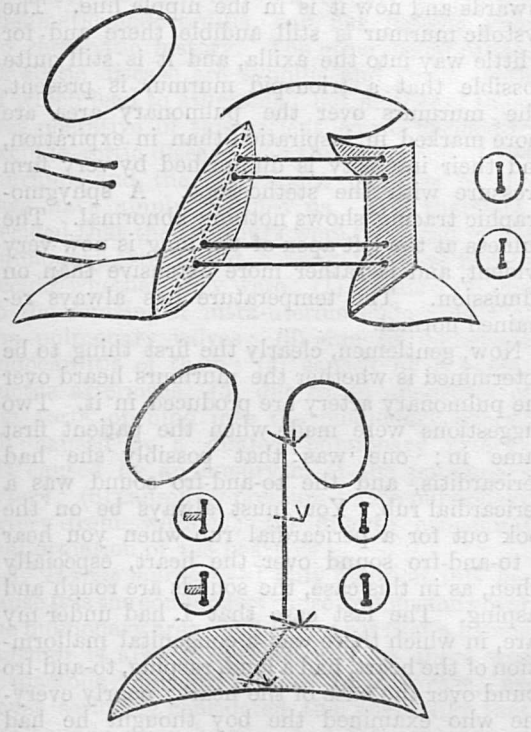
Now the parts are ready to be brought together.

For a long time I used the hare-lip pin to approximate the deep parts. The objection which I found to the use of this pin was that if left in too long it would cut its way out, and so make a horizontal cut through lip, while if taken out sooner, sometimes union had not taken place, so that the parts gave way.

The reason why the pin cuts its way out is that the tissues between the pin and the silk used to keep the parts in apposition are pressed upon, so that their blood-supply is cut off, and sloughing consequently occurs.

What I have found the best are ordinary mother-of-pearl shirt-buttons connected together with wires. I use two buttons on either side. A wire is threaded through two holes of a button, and the ends armed with needles. These are passed through the skin on the maxillary side and well into the muscle and brought out just in front of the mucous membrane, and then passed in reverse order through the muscle and skin on the other side, where, after they have traversed the small holes of a similar button, the wires are tightened up, twisted, and cut short. The upper pair of buttons is then fastened in the same way. The deeper part of the two surfaces having been thus drawn together, I employ horse-hair sutures inserted through the very edge of the skin to bring together the rest of the raw surface. The

first of these should be that which secures the exact co-aptation of the prolabium.



Dressing.—I have given up the use of strapping, to which there are many objections, and now cover the parts with flexible collodion. I first lay a narrow strip of boracic lint over the wound to prevent the collodion from getting between the edges. I then put on a thin film of sal alembroth wool and paint the whole with flexible collodion. On the fourth day after the operation, I lift up the edge of the dressing and cut the wires beneath one of the lower buttons, leaving the rest of the dressing untouched. On the fifth day, I do the same with one of the upper buttons. On the sixth day, I remove the dressing and all the sutures. I then dress the wound with an ointment of zinc oxide and vaseline.

It is best not to apply collodion a second time, as it is liable to set up an attack of eczema. By the end of six days the union is so firm that it is quite unnecessary to support it by strapping or any other device.

My diagrams will show how the lower flap on the maxillary side is used to avoid the notch upon the free edge of the lip, while the upper flap, when carefully adjusted with its tip against the nasal septum, forms the lower margin of the nostril.

If the edge of the premaxillary bone is prominent, there may be some difficulty in bringing together the raw surfaces on either side of the cleft. Usually, however, this can be done after the cheek has been properly freed from the maxilla. In rare cases it may be necessary to free the central part of the lip from the premaxillary bone. I have never found it necessary to force back this bone in single hare-lip. If good union is obtained, the steady pressure of the upper lip will soon press the prominence into its proper place.

On Murmurs produced in the Pulmonary Artery.

A CLINICAL LECTURE BY DR. HALE WHITE.

GENTLEMEN,—The patient I am showing you to-day is of exceptional interest, because she has a most unusual murmur; and although in many ways the case is so uncommon that you may never see another like it, and also I am by no means sure of the cause of the murmur, yet I do not think we could have a better case for a clinical lecture, because it makes us consider the whole question of pulmonary murmurs.

Annie C., æt. 24, was admitted on August 23rd, 1895, into Mary ward. She came complaining of swelling of the legs and abdomen. The family history is good, and in no way bears on the case. The patient is a temperate woman, who has never had syphilis nor rheumatic fever. She is engaged in ordinary household work, which is not particularly arduous. She has had three children; the last was born early in July. Her labours have always been easy and straightforward.

Last January she noticed that her ankles swelled after much standing, and some time before that she felt some palpitation and shortness of breath and occasional cough. The œdema of the feet became worse, and as these symptoms did not subside after the confinement, she came into the Hospital. Three days before admission she had some hæmoptysis.

On admission.—She is pale; there is no lividity, and no capillary pulsation can be obtained.

Circulatory system.—The pulse is 90 and does not feel abnormal. The cardiac impulse cannot be seen owing to the large development of the breasts. Pulsation is visible to the left of the sternum, about the second and third ribs. The impulse, which is heaving in character, can be felt in the sixth space, a quarter of an inch

external to the nipple line. A systolic thrill can be felt in the pulmonary area, and pulsation can be felt through the diaphragm at the ensiform cartilage. The cardiac dulness extends outwards as far as the left nipple, and slightly to the right of the sternum, but otherwise it is normal. Over the pulmonary area there is a loud, rasping, to-and-fro murmur, the systolic part of which is more rasping, but louder than the diastolic; it is conducted upwards and to the left. The diastolic murmur can be heard a little way down the sternum; both murmurs are very much less loud on the right of the sternum than on the left. At the apex there is a systolic murmur, which from its characters is, perhaps, the same as that heard at the base: it is not conducted into the axilla. There is a systolic murmur nearer the ensiform cartilage, which is probably produced at the tricuspid orifice.

Respiratory system.—The only thing abnormal is that the resonance is distinctly impaired on the left side, in front, between the clavicle and the third rib. This impairment extends from the sternum out to the shoulder. Bronchophony is slightly diminished over this area, and perhaps the air does not enter so well as at the right apex.

The abdomen contains fluid, and there is much œdema of the legs. The liver cannot be felt. There is no albumin. She was ordered Tinct. Digitalis ℥ 10; Tinct. Nucis Vomicæ ℥ 10; Caffeine gr. 10; Sodæ Salicylas gr. 5; Aq. Chloroformi ʒi. ter die; and 30 grains of each of Sulphate of Sodium and Sulphate of Magnesium every morning.

Under this treatment she improved considerably in every respect, and as you see now she is fairly well when she does not exert herself much. She was kept in bed for about a fortnight. The œdema of the feet and the ascites have disappeared. The physical signs have slowly changed. The diastolic murmur has become less marked and is now very short and faint. The systolic murmur remains the same, except that, perhaps, it is not quite so harsh; gradually there has, however, developed a long, loud, harsh, blowing sound, occupying the whole of the systole and the greater part of the diastole. This is best heard over the second left costal cartilage, and from there its intensity is rapidly lost downwards and to the right, but it can be heard some distance up to the left, and also it, and the systolic murmur, can be heard between the left scapula and the spine at the back. The systolic and diastolic murmurs are heard through it, so to speak. The thrill is still well marked, but it is now prolonged a little into the diastole. The apex has gradually shifted inwards and now it is in the nipple line. The systolic murmur is still audible there and for a little way into the axilla, and it is still quite possible that a tricuspid murmur is present. The murmurs over the pulmonary area are more marked in inspiration than in expiration, and their intensity is diminished by very firm pressure with the stethoscope. A sphygmographic tracing shows nothing abnormal. The dulness at the left apex of the lung is now very evident, and is rather more extensive than on admission. The temperature has always remained normal.

Now, gentlemen, clearly the first thing to be determined is whether the murmurs heard over the pulmonary artery are produced in it. Two suggestions were made when the patient first came in; one was that possibly she had pericarditis, and the to-and-fro sound was a pericardial rub. You must always be on the look out for a pericardial rub when you hear a to-and-fro sound over the heart, especially when, as in this case, the sounds are rough and rasping. The last case that I had under my care, in which there was a congenital malformation of the heart, had a loud, rasping, to-and-fro sound over the base of the heart; nearly everyone who examined the boy thought he had pericarditis, a supposition which turned out to be quite incorrect. However, we decided that the patient before you had not got pericarditis, for the systolic sound was conducted far up to the left; the diastolic was conducted down the sternum. The pericardial dulness was not increased; she had no pain nor tenderness, and the temperature was never raised. The course of the case has shown that we were correct in excluding pericarditis, for the murmurs are not now such as could be produced by the pericardium, and indeed in no way has the case shown any resemblance to pericarditis.

The next suggestion was that the patient had aortic disease, and that is most important. You know, of course, that an aortic to-and-fro murmur is usually best heard to the right of the sternum; but you must never forget that, for some unexplained reason, an aortic to-and-fro murmur is often heard better to the left of the sternum than the right. Unless you bear this in mind you will constantly make mistakes. However, in our patient we decided that the murmurs were not aortic. In the first place, the systolic murmur went much too far up to the left, and diastolic was very feebly conducted down the sternum. The pulse was not

suggestive of aortic disease. Then, also, aortic disease is very rare in young women, apart from rheumatic endocarditis, and our patient gave no rheumatic history. The other usual causes of aortic disease are syphilis and strain, both of which lead to atheroma; but neither of them was operative in this patient, so we decided to exclude aortic disease, and the alteration of the murmur and the subsequent progress of the case have amply justified us. We, therefore, decided that the murmurs were produced in the pulmonary artery, and, consequently, we had to decide whether they were: (1) hæmic; (2) due to the remains of intra-uterine endocarditis of the pulmonary valves; (3) due to malignant endocarditis of them; (4) caused by a patent ductus arteriosus; (5) due to an aneurysm of the aorta opening into the pulmonary artery; (6) caused by a dilated pulmonary artery; (7) caused by an aneurysm of the pulmonary artery; (8) caused by pressure on the pulmonary artery from without; (9) due to congenital malformation of the heart.

1. *Hæmic murmur.*—I only mention this because it is the commonest cause for murmurs over the pulmonary area; but remember that a hæmic murmur is always systolic, and as there was a diastolic murmur present in this case, we never seriously considered the possibility that the sounds were hæmic, and the presence of backward signs also showed that they were organic. Then, too, you will notice that the lungs had escaped from the backward signs; the cardiac dulness extended to the left of the sternum, and the right ventricle could be felt beating through the diaphragm, all these facts confirming the view that the trouble was organic and in the pulmonary artery or right side of the heart.

2. *Intra-uterine pulmonary endocarditis.*—Endocarditis on the left side of the heart in intra-uterine life is excessively rare, while endocarditis on the right side—apart from malignant endocarditis—seldom occurs after birth; but intra-uterine right-sided endocarditis is by no means rare. It affects the pulmonary valves with much greater frequency than the tricuspid, and as a result of it there is obstruction to the propulsion of blood through the orifice of the pulmonary artery. As the blood in the right ventricle must find an exit somewhere, it does so through the, as yet unclosed, septum ventriculorum, and consequently the complete closure of this is prevented and the child is born with a narrowed pulmonary orifice and a septum ventriculorum which is patent at its upper part. Most of such children are when born uniformly livid; they are cold, their fingers are clubbed, and a loud systolic murmur can be heard over the pulmonary orifice. Usually they die in early childhood; but if the pulmonary obstruction is not great they are not livid, and by no means uncommonly survive some years. In such cases a systolic murmur, loudest over the pulmonary orifice and conducted upwards and to the left, can be heard, and the patient is always more or less short of breath. Probably in these cases the pulmonary obstruction has not been sufficient to prevent the closure of the septum ventriculorum, and the hypertrophy of the right ventricle has been well maintained. The suggestion was quite rightly made that this was what was the matter with this patient, but I think the following objections will dispose of this view. Two great dangers threaten to these patients; one is that they will die in childhood or young adult life from phthisis. You will remember that phthisis is not commonly associated with left-sided heart disease, it is said because the lungs are constantly congested, owing to the difficulty the blood has in passing through the diseased left side, and, therefore, it is easy for you to remember that pulmonary tuberculosis is a common danger when, in association with obstruction at the pulmonary valves, the lungs contain less blood than they should. The other danger is that the heart in these cases breaks down at puberty, backward signs quickly develope and the patient dies. This is not surprising when you remember that the rapid growth of all the organs in any way associated with the sexual function, and the addition of a new function must increase the demand made upon the circulatory power of the heart. But even supposing that puberty be survived there are other dangers ahead, for it is a well known fact that extra calls are made upon the cardiac energy during pregnancy, and that then, therefore, a diseased heart is very liable to give way. You will, I dare say, in the course of your practice, be consulted by a mother as to the best way to bring up a child with pulmonary stenosis who has survived early childhood. You should direct that he should lead a quiet life in the country, with plenty of fresh air, in order, as far as possible, to avoid tuberculosis, and that while he should not be coddled more than necessary, he should indulge in no exercise which would throw any strain upon the heart. I have recently seen a little boy, aged 12, who gets on very well, and is very happy, and amuses himself chiefly with driving, fishing and croquet. Then you must warn the

mother to take especial care during puberty, and even if it be survived, neither sex should marry. It is true that about three months ago there was in Stephen ward a man with congenital pulmonary stenosis, who was over thirty, and seemed very little the worse for it; but please remember that such cases are in the highest degree exceptional.

To return to the woman you see before you. I think it is extremely unlikely that a woman of the working-classes could have pulmonary stenosis, and could by the age of twenty-four have borne three children, and yet be as well as she is. But the sounds alone are enough to make us very suspicious of such an explanation, for whilst when the aortic valves are diseased a to-and-fro murmur is common, for some unexplained reason a diastolic murmur due to congenital disease of the pulmonary valves is one of the rarest murmurs we hear. Further, disease of the pulmonary valves would quite fail to explain the loud rumbling sound running through systole and diastole which this patient has developed. So, for all these reasons, we have decided that she is not the subject of congenital endocarditis of the pulmonary valve; and I may add that such a view would fail to explain the dulness at the right apex, for there is no evidence of active phthisis there, and phthisis once developed in patients suffering from disease of the pulmonary valve rarely becomes quiescent.

3. *Malignant endocarditis.*—This is the only form of right-sided endocarditis which developes after birth and affects the pulmonary valves. It is not excessively rare. I find that we average one case a year at Guy's of right-sided malignant endocarditis, and that the tricuspid valve is affected four times for every once that the pulmonary is implicated. Some years ago a man was under my care in whom the diagnosis was easy, for he had rigors, pyrexia, and a loud, rasping, systolic murmur over the pulmonary valve, conducted upwards and to the left. At the post-mortem examination enormous fungating masses were found on the valve. There is at present, in 33 bed, Stephen ward, a man in whom probably the same condition is present.

When this woman first came in we thought that possibly she too might be suffering from the same disease, for although in congenital pulmonary disease a diastolic murmur is so excessively rare, it has often been heard when malignant endocarditis has affected the valve. Then, too, although the history did not very well accord with such a view, it was possible that her malignant endocarditis was due to infection after delivery. We have had one or two instances of this in the Hospital lately. Her anæmia was also in favour of malignant endocarditis. But as her temperature has never been raised, and she has improved so considerably, and has developed a long sound running through systole and diastole, this view is very unlikely, and now I do not think she is suffering from malignant endocarditis. Still, it is well to remember that this disease may be very chronic. I have known it linger on for months, and sometimes the patient gets well enough to go out, and then returns to the Hospital later and dies, it may be six months after the first onset of symptoms. Then, too, I have seen a patient with every symptom of the disease get quite well.

4. *Patent ductus arteriosus.*—This may be associated with congenital disease of the pulmonary valve, but we have seen reason to suppose that this does not exist. A patent ductus arteriosus, apart from other cardiac deformity, is so very rare, that one hesitates about the diagnosis. Dr. Fagge* says, "very few cases are on record in which a patent ductus arteriosus has given rise to a murmur." In his own case there was a systolic murmur loudest at the fourth and fifth left costal cartilages, and diminishing in intensity downwards and towards the axilla, and a wavy partly musical murmur, audible best at the second left costal cartilage, directly following the second sound, and occupying the first four-fifths of the diastole. He quotes a case from Kaulich in which there was a prolonged diastolic rasping murmur, most intense over the third rib, and a systolic murmur at the same spot. Dr. Taylor, also writing in the Guy's Hospital Reports, quotes a few other cases; in one there was a systolic murmur, and in the others either no murmur could be heard or other lesions were present. My only experience of a patent ductus arteriosus, is that when I was Demonstrator of Anatomy I examined a subject in the dissecting-room, in which a patent ductus arteriosus was about the calibre of an anterior tibial artery. The injecting fluid had passed from the aorta through the patent ductus into the pulmonary artery, which was consequently fully injected. The subject was a man, aged 53, who died in the City of London Infirmary, and Dr. C. H. Buncombe told me that when there he had a loud systolic murmur limited to an area of two and a half or three inches, heard best over the second left intercostal space close to the

* Guy's Hospital Reports, 1872–73.

sternum. I think you will agree with me that, judging by the murmurs only, it is possible for the woman before you to have a patent ductus arteriosus, and further—as in Dr. Fagge's case—the extra quantity of blood in the pulmonary artery may cause the backward signs from which she suffers, although there will be no evidence of any backward signs in the lungs. But this malformation is excessively rare, and such a diagnosis quite fails to explain the dulness at the left apex.

5. *An aneurysm of the aorta opening into the pulmonary artery.*—There are several cases of this on record, and Dr. Taylor has, in the Guy's Hospital Reports, collected them. Among twenty-six cases, seven died suddenly; among the remaining nineteen, in seven a systolic murmur was present, in six there was a continuous murmur occupying systole and diastole, and in six there was a to-and-fro murmur. In several a thrill was present. Many of these nineteen died soon after the rupture; but, of the cases in which from the appearance of things at the post-mortem, it appeared that the opening between the aorta and pulmonary artery had existed some time, in all but one there was a continuous murmur occupying the systole and diastole, heard best over the base of the heart, and often best over the pulmonary artery. Thus you will see that, judging by the murmurs only, it is very probable that this woman has an aneurysm of her aorta opening into her pulmonary artery; but such a thing in so young a woman is very rare; and again, aneurysm in women is almost always due to syphilis, from which this woman is free; but still you must remember that two years ago there were in Clinical ward two young adults, one a woman and the other a man. Neither had had either syphilis or malignant endocarditis, but both died from intracranial aneurysms. It is not easy, however, on this supposition, to explain the dulness at the left apex, for an aortic aneurysm could hardly reach up to the left shoulder without giving pain and pressure symptoms.

6 *An aneurysm of the pulmonary artery.*—Aneurysms of the branches of the pulmonary artery are by no means uncommon in phthisis; but an aneurysm of the main trunk is so rare that we know little of its physical signs. Judging by our knowledge of aneurysms of the aorta, we should hardly expect the murmurs we hear here, and we have just seen that it is extremely unlikely that this woman has an aneurysm.

7. *Dilated pulmonary artery.*—This is by no means uncommon, and is nearly always due to increased pressure in the artery, as a result of disease of the lungs on the left side of the heart; the artery becomes thickened, dilated, and it may be atheromatous. The signs produced are very variable. Sometimes the condition is found in the post-mortem room when it was never suspected during life. On the other hand, it may be diagnosed from the presence of a murmur heard about the second and third left intercostal spaces. Very few authors have paid much attention to the diagnosis of dilatation of the pulmonary artery, but Dr. Goodhart has particularly called attention to these cases. Now we can understand that the passage of blood from the right ventricle through the pulmonary orifice into the dilated artery would give rise to a systolic murmur. Such a murmur is common enough on the left side of the heart when the aorta is dilated. Also if the increased pressure in the pulmonary artery were very great the pulmonary orifice might stretch, and regurgitation with a diastolic bruit would result, and you will find instances of both these results in Dr. Goodhart's paper in the Guy's Hospital Reports; but I must confess that I do not understand how a dilated pulmonary artery could produce the long sound we hear occupying both systole and diastole. Then we must remember that in this case we have very little cause for a dilated pulmonary artery. I do not think that the dulness at the left apex indicates nearly sufficient pulmonary obstruction to cause it, and although it may be that the apical murmur is caused by some mitral regurgitation, still the condition of the lungs and the general state of the patient does not point to that being severe enough to cause a very dilated pulmonary artery.

Before leaving this subject, I ought to remind you that not long ago, Dr. Bryant made a post-mortem on a young woman in whom the pulmonary artery was dilated and atheromatous without any obvious cause. Such a condition must be excessively rare, and I do not know of its having been diagnosed during life.

8. *Pressure on the pulmonary artery from without.*—The dulness at the left apex, together with the diminished bronchophony, is very suggestive of thickened pleura, and so it has been pointed out that possibly this may in some way be constricting the pulmonary artery, and causing the murmurs; and it is, perhaps, in favour of this view that they are of different intensity in expiration and inspiration, and on deep and light pressure; but thickened pleura

constricting the pulmonary artery ought to cause a systolic murmur as the blood passed through the constriction, and possibly a diastolic murmur when the blood fell back a little on to the closed pulmonary valves in diastole. Not only, however, is such a condition excessively rare, but also as the pericardium is continued on to the pulmonary artery, it is very doubtful whether such pressure could do more than implicate the left branch, and I do not see how, even then, we could explain the long sound we have here. Although, therefore, this explanation is at first sight very tempting, there are very serious objections to it.

9. *Congenital malformation of the heart.*—A great many malformations of the heart have been described, and it is too wide a subject to discuss now. Nor is it necessary, for in the first place we must remember that it is excessively rare for the sufferer from cardiac malformation to attain the age of this patient; most die in early childhood or at puberty; and secondly, these malformations are so uncommon in those who survive their birth for long that no one can have an extensive clinical experience of them, and consequently the differential diagnosis between them is almost impossible. The only one that is worth discussing separately from a clinical point of view is a patent ductus arteriosus, and that we have already mentioned. You will understand how difficult the diagnosis of congenital malformation is when I tell you I have never seen or made a post-mortem examination on a case in which the malformation that was supposed to exist during life has been found after death. I think you ought to rest content if you can make out whether your patient is suffering from congenital pulmonary endocarditis with a patent septum ventriculorum, or from *some* congenital malformation.

The murmurs heard in the present case are very like the last case of congenital malformation under my care, in which there was a patent septum ventriculorum and a communication between the right ventricle and aorta. You will notice that this is much the same thing as a communication either by patent ductus arteriosus, or aneurysm between the pulmonary artery and aorta, and thus this case lends some support to the view already expressed, that it is on the whole likely that some communication between these two vessels exists in the patient before you.

Our time is now up, and, therefore, I am afraid we must conclude without discussing the other symptoms and the treatment.

Hospital News.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	6.	Large abscess in temporal fossa of doubtful origin.
	11.	Stricture of urethra; retention and dribbling.
	13.	Mastoid abscess. Antrectomy.
	15.	Undescended testicle.
	16.	? Rodent ulcer.
Charity	14.	Sarcoma of upper end of tibia.

Cases under Mr. Davies-Colley.

Cornelius	1.	Punctured wound in region of hip. Fractured ribs.
	6.	Acute synovitis of knee-joint.
Lydia	1.	Breast tumour, found on removal to be cysts in indurated breast tissue.
	7.	Bronchocele.
	8.	Psoas abscess on right. Lumbar abscess on left side.
	12.	Conjenital talipes equino-varus.
	17.	Chronic bursitis (bursa patellæ).
	18.	Lupus of nose, lip, gums, palate.
	19.	Chronic enlargement of glands in neck.
	Oct.	Scald of throat. Tracheotomy.
Luke	4.	Anthrax.
	20.	Anthrax.
	20.	Strangulated inguinal hernia.
	21.	Inguinal hernia. Hydrocele.

Cases under Mr. Lucas.

Accident	2.	Run over. Hæmorrhage from end of penis. Frænum torn. Bruising across pubes.
	20.	Necrosis of tibia after compound fracture. Sequestrotomy.
	32.	Dislocation outwards of patella.
Job	8.	Right femoral hernia. Left varicocele.
	18.	Necrosis of lower jaw.
	21.	Irreducible omental inguinal hernia.
	25.	Ulceration of rectum after Maltese fever.
Charity	4.	Suppurating bursa patellæ.

Cases under Mr. Golding-Bird.

Martha	3.	Caries of spine. Psoas abscess.
	6.	Painful stumps after Symes' amputation.
	7.	Hæmorrhoids.
Lazarus	11.	Malignant pustule on forehead.
	12.	Scarred and pigmented rash. Epitheliomatous tumour removed from skin; recurrence in axillary glands. ? Diagnosis.
	14.	Talipes valgus. Tuberculous periostitis and bursitis over inner malleolus.
	15.	Carcinoma recti.

LAZARUS 17. Mastoid abscess.
19. Gangrene of finger.
20. Myxo-enchondroma of parotid.

CASE UNDER MR. JACOBSON.

NAAMAN 30. Suppurating corn on great toe opening into joint.

CASE UNDER MR. LANE.

JOB 12. Varicose aneurysm in arm, due to wound with small piece of steel, which was found in the aneurysmal sac.

CASES UNDER MR. DUNN.

LAZARUS 2. Enlarged glands in axilla. ?Tuberculous.
3. Hydrocele of tunica vaginalis.

In the Out-Patients' Department.

CASE UNDER MR. SYMONDS.

Baby of six months was brought in with the right arm rotated inwards. The condition was stated to have existed since birth. Otherwise the child was in very good health, and there were no signs of paralysis in any other part of the body. Delivery was instrumental, but further details could not be obtained. The condition of the right shoulder appeared, except for fixation, perfectly normal, there was no inflammation, no deformity, and the tissues seemed as full on the right as on the left side of the neck.

On examination.—The joint was found to be capable of passive movement without difficulty. On rotation, the head of the humerus was felt to rotate under the thumb in the axilla. On releasing the part the arm fell back to the original position of inward rotation.

Mr. Symonds remarked that, from the symptoms noticed before manipulation, the injury was likely to be one of the following five :—

(1) Spasm of the internal rotator muscles of the arm ;
(2) Paralysis of the external rotator muscles of the arm ;
(3) Epiphysial fracture combined with axial rotation ;
(4) Adhesion in the joint ;
(5) Syphilitic epiphysitis.

The latter is rendered improbable by the absence of pain on passive movement of the arm ; by the absence of signs of inflammation, and by the absence of other syphilitic symptoms. Epiphysial fracture and adhesions are eliminated by the ease and perfection with which the limb may be passively rotated.

It must then be due either to spasm of the internal rotators or paralysis of the external rotators ; either of these conditions might be caused by a cerebral lesion occurring at birth ; the latter might also be the result of damage done to the nerves supplying the external rotators—viz., the suprascapular and circumflex nerves.

The diagnosis preferred was that of spastic condition of the internal rotator muscles of the arm.

Treatment.—Hyd. c. Cret. et Soda gr. iij. n. et m., as an absorbent either for local syphilitic or cerebral lesion.

In the "Charity."

A CASE OF SPONTANEOUS EXPULSION.

C. M., æt. 39 ; multipara ; confined October 27th, 1895. On examination, the os was found to be fully dilated and the membranes ruptured. The patient had been in labour for over nine hours, and had lost a considerable quantity of blood. On external examination, the uterus was found to be tightly contracted. The head could be felt in the right iliac fossa, and the right side was anterior. On subsequent vaginal examination, the ribs could be distinctly felt ; neither of the extremities could be reached, and the left side of the back was ascertained to be presenting. The resistance to delivery was evidently at the brim, and due to the wedge-shaped position of the child. Delivery was subsequently effected by the fœtus being driven through in this position, the head passing the brim with the upper part of the thighs, and the legs fully extended. The placenta followed the fœtus with the same contraction. There was a distinct "caput" formed over the centre of the back about the lower dorsal and upper lumbar regions. The child was quite dead, but had not been dead long. The age was about seven months ; length, fifteen inches from the toes to vertex ; length of external auricle, twenty-eight m.m. Both testicles were descended and in the scrotum. The eyes were open and the lashes formed. The greatest diameter was that of the head plus the thighs, and measured four and a half inches. Weight of fœtus, two and three-quarter pounds. The mother is progressing satisfactorily.

The Sustentation Fund.

SINCE the last announcement in this column some important progress has been made. Few people will have failed to read Mr. Gladstone's eloquent and convincing appeal ; but it is fitting that it should be recorded in our columns, and we accordingly reproduce it below, together with the leading article from *The Times*, a letter from Dr. Samuel Wilks, and a warm tribute from *Punch*. As may be imagined, Mr. Gladstone's letter has not been without response, but it is yet too early to estimate the full result.

The Committee of old Guy's men continues to grow, fresh names are coming in every day, and in the next issue of the GAZETTE it is hoped to publish a fairly complete list of those whose sympathy towards the Hospital still remains strong and unaffected by time and absence.

The practical interest which is being taken in the Fund by a considerable number of present students is most encouraging, and for the very valuable help which they, as well as various old Guy's men and Sisters, have already rendered, the Secretary to the Treasurer desires to express his grateful appreciation. It is already sufficiently evident that the help and influence of our own

people may prove an important factor in the success of the Fund, and certainly will do so if everyone's assistance is forthcoming.

The public-spirited and generous action of the "Dis-Guysed Minstrels" seems likely to mark an epoch. The following entertainments have already been arranged, to the great satisfaction of the respective localities :—

Saturday, 28th December	...	Brockley.
Monday, 30th "	...	Peckham.
Wednesday, 1st January	...	West Norwood.
Thursday, 2nd "	...	Woodford.

Probably the list will be completed with two further engagements. Full announcements will shortly be made, and any of our readers resident in the respective neighbourhoods will, of course, take tickets for themselves and all their friends.

At the Smoking Concert held on Saturday evening last in the College, a collection on behalf of the Hospital realised £4 10s. This spontaneous act of goodwill is a gratifying proof that those who know the place best believe in its claims.

(From *The Times*, October 30th, 1895.)

We publish this morning a letter from Mr. Gladstone on the financial condition of Guy's Hospital, which can hardly fail to call forth a prompt and generous response. Mr. Gladstone has been for many years a Governor, and he has therefore an official right, in addition to that which is derived from his great position, to raise his voice in behalf of an institution, the value of which it would scarcely be possible to exaggerate. It appears from his letter, as well as from the statement made by the Treasurer, and given in full detail in his report to the Governors, that the funds bequeathed by Thomas Guy were required, under the provisions of his will, to be invested only in land, and that the rentals derived from this land yielded an income which increased progressively up to the year 1880, when the total amount reached the sum of £40,000. Since that time decrease has been steady and continuous, in so much that the revenue of the charity is now only half of what it was fifteen years ago, while the claims upon it have as continually increased, and are certain, with the growth of population, to increase still more in the future. In 1885 the Governors were compelled by want of money to close some of the wards; and in the following year they organised a special appeal, by which a sum of £100,000 was collected. The additional income hence derived was, of course, inadequate to the necessities of the case, and it has been requisite to supply the deficiencies from the capital. Of the whole sum, only about £18,000 now remains, and this will barely be sufficient to meet the liabilities of the current year. The deficiency to be met annually will be at least £14,000; and the appeal now made has for its object to provide this amount, partly from the interest of large donations, partly from the increased subscriptions which are as urgently needed.

We have so often dwelt upon the vast importance of the London hospitals to all classes of the community that it would be superfluous to restate considerations of an obvious character, while it would be difficult to add anything, either in force or cogency, to the appeal of the venerable statesman, whose pen has never been employed in a better cause, or in one which ought more surely to command the sympathies of his fellow-countrymen. Mr. Gladstone justly points out that the City of London contains, side by side with boundless wealth, a vast population which is subjected to the pressure of boundless want; and this latter population, which is forced to be where it is in order to obtain a living by ministering to the requirements of wealth, is exposed, by circumstances utterly beyond the control of those who form it, to innumerable causes of disease or of injury. When suffering from the effects of these it has no resource but the hospitals, no other possibility, in an enormous number of cases, of securing the conditions essential to the restoration of health. One hundred beds in Guy's Hospital are now closed for want of funds; and, as the average stay of an in-patient last year was twenty-five days, it follows that between fourteen and fifteen hundred persons during that time have been deprived of the benefits which those beds were calculated to confer. Nor have the poor been the only sufferers. The hospitals of London are the great sources of medical and surgical skill for the entire community; and the efficiency of their work may be of as vital concern to the millionaire as to the pauper. Those who respond to Mr. Gladstone's appeal will not merely be ministering to the needs of a charity, and supplying the wants of the poor, but they will be strengthening the hands of the medical profession in its life-long battle with disease, and will be assisting to secure the blessings of health to all who are in danger of being deprived of them.

Hawarden Castle, Chester,
18th October, 1895.

My Dear Sir,

I feel that the recommendation, which on behalf of Guy's Hospital you have requested from me, will be greatly deficient in point of weight and authority. Nevertheless after looking into the circumstances of the case as they stand, I cannot refuse to make it, and this with all the earnestness I can command.

In order to see and feel it as it deserves to be seen and felt, we must endeavour to forget the beneficent but wealthy and more easy-going Guy's Hospital of sixty years ago, when I became a Governor. We must regard it as an institution aiming at the most Christian ends, of elementary necessity, never too rich for the work it had to do and now, through no fault of its own, cut down to one-half of its means.

The revenue, that was over £40,000 has sunk to £20,000; but the surging sea of want all around the Hospital has grown wider and deeper from year to year.

I wish, but vainly wish, it were in my power to bring London, and not least the City of London strictly

so called, to understand the greatness and urgency of the case. In your Report as Treasurer you inform us that, from want of pecuniary means, one hundred beds are at the present time, and have been for some past period, unemployed and useless. This statement is of itself sufficiently grave, but it is not all, nor is it the gravest of what you have to tell. We have to make ourselves understand that the arrest and contraction of efficiency thus indicated will be followed, at the close of the present year, by a further and I fear yet heavier downfall, and that, unless a courageous and serious effort is made to avert the calamity, an appreciable portion of Guy's Hospital must become a solitude. But such a solitude would be indeed a desolation.

This is surely a very grave subject of contemplation for the masses of persons, resident in London, who are not too poor to make some contribution out of their moderate means towards the end in view. Let any resident in London, not absolutely poor, consider the hundreds of thousands annually which his large class has saved through the low price of bread; let him compare it with the £14,000 per annum which I take as an estimate of your deficit, and will he not thereupon conclude that if the threatened calamity should overtake the Hospital it would be the infliction of a public disgrace to the London, and especially the South London, community; a disgrace the more grave when we remember that it is the immense boon that the people have received in the low price of bread, which has reduced your revenues and crippled your means of meeting the wants and distresses of the sick and of those suffering from accidents among them. And surely the consequence ought to be that each man, on his responsibility, living within the radius of your operations, should do what he can to swell the stream of bounty on an emergency such as this.

But if the net of obligation be cast thus wide over the community, let us not forget how that obligation is enhanced with respect to those masses of wealth concentrated in the City and the West End; and indeed here we may include all that portion of the community to meet whose wants, both necessary and conventional, there have come into existence other and larger classes such as create the demand for Hospital accommodation.

No dimness of mental vision can hide from us the fact that in the vast metropolis of this country there subsist side by side two marked, nay glaring, social characteristics; the one boundless wealth, and the other boundless want. And, when a crisis arises, at which, want continuing its normal growth, the ordinary resources for meeting it have undergone abnormal reductions, the case is one which in the face of the wealth of London appeals not only to the sense of kindness, but perhaps even to the sense of shame.

A word on one remaining point. I rejoice to find, upon the best examination I am able to make, that Guy's Hospital, instead of being pampered by its former wealth, is distinguished among sister institutions by the vigilant economy of its administration, so that it affords to all contributors the best guarantee for attaining through their contributions a maximum of good.

I remain, dear Mr. Treasurer,

Very faithfully yours,

W. E. GLADSTONE.

The Treasurer of Guy's Hospital.

To the Editor of THE TIMES.

SIR,—As chairman of the Sustentation Fund of Guy's Hospital, I trust you will permit me to endorse Mr. Gladstone's letter in support of his appeal for funds to preserve this most important institution in its original integrity. I, like him, have been fifty years connected with Guy's Hospital, but as a working member of the medical staff. Having, moreover, lived in the neighbourhood of Guy's, I have an intimate knowledge of its value and usefulness. I also know how vital a necessity this institution has always been to the needy inhabitants in its vicinity. They have been in the habit of applying there for the relief of all their bodily ailments; during all hours of the day working men and women might be seen proceeding there to have their wounds and injuries relieved. Then cases of fever and sudden illness always found immediate admission within its walls without card or recommendation. Now much of this important work is arrested for want of funds, and the poor are suffering proportionally.

In pleading for a general hospital I am asking only for the support of an institution which has become almost one of the necessities of life in the working classes. There may be other charities valuable for their special purposes, but a general hospital is an absolute need for the working man. Should he, for example, break his leg, it is impossible that he can have all the attendance and appliances which the case demands at his own home. He must of necessity go to a hospital, where he receives the best treatment and able to resume his work in the shortest possible time. Society is the gainer by this means of assistance, and were it to cease through lack of funds, it would be incumbent on the County Council or the State to provide similar means of relief for the necessitous. There is no lack of charity in London, but the funds are often diverted into wrong channels. A number of small institutions which swallow up their income in working expenses are so numerous that the late Dean Sydney Turner reported, on his return from a Government Commission, that in France the same amount of medical charity was administered for half the sum expended in England.

It is the obvious duty of employers of labour to assist those institutions which daily relieve their men gratuitously when wounded and otherwise injured. Nor can the fact be too forcibly pressed upon the benevolent generally that the first necessities of the poor should be relieved before money is lavished on the propagation of one's private fads for the healing and regeneration of suffering humanity. I have tried in vain to induce a lady to subscribe to a West End hospital where probably her own domestics had advice or her relatives even found

a shelter when meeting with accidents in the park; she is actuated by sentimental motives alone, and her money goes to cure cancer, to instruct idiots, and to build lifeboats.

The general hospitals are a prime necessity to the community. We should no longer see in the papers "Drunk or Dying?" had these institutions the means to enable them to take in cases of a doubtful nature and watch them for a few hours to gain a true diagnosis. The public cry out, but do not provide the funds. If the community could be convinced of the absolute necessity of these institutions for the poorer classes, and consider those before they enrich smaller places having other objects of doubtful utility, there would be no need for this continual appeal for help. Guy's is in the unfortunate position of having supplied to its neighbourhood the relief required, and this is now reduced to one-half. Thanks to you personally for the support your own leader will give.—I am, Sir, your obedient servant,

SAMUEL WILKS,
Consulting Physician to Guy's Hospital.

72, Grosvenor Street, Oct. 30.

OUR NEW KNIGHT HOSPITALLER.

(From *Punch*.)

["We must regard it (Guy's Hospital) as an institution aiming at the most Christian ends, of elementary necessity, never too rich for the work it had to do, and now, through no fault of its own, cut down to one half of its means."—*Mr. Gladstone's Letter on Guy's Hospital.*]

"'Twere good you do so much for charity."
Merchant of Venice, Act. IV., Sc. 1.

Knight of St. John or Malta? Nay!
But needs of a less knightly day
The new Knight Hospitaller pleads.
Once foremost in the press of fight,
We find to-day the good grey knight
Militant still—for human needs.

No more with levelled lance in rest,
But, the Cross still upon his breast,
A knightly almoner is he.
Not as of old with flashing steel,
But flashing words, he makes appeal
In the great Cause of—Charity.

Punch seconds it with warm goodwill.
It sends a most unwelcome chill
Through every generous heart to think
That the great gift of THOMAS GUY
Should suffer stint, or seem to die,
Because lands fail and rentals sink.

One hundred empty beds! Whilst wealth
Swells in the West, and shaken health
And sudden anguish scourge the East?
It must not be, or how may we
Who hold full stock and store in fee
Enjoy the coming Christmas feast?

Think! Fifteen hundred poor kept out,
And left in lonely pain and doubt,
Because the funds of Guy's so fail:
The sufferer's peace, the surgeon's skill
Checked, because Charity feels a chill!
Punch on his Public would prevail

To step into the breach, and brim
Guy's store again, as urged by him
Who now no party plea prefers,
But a far wider, higher plea,
In the great cause of Charity,
Newest of Knight Hospitallers

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

John Keats.

SIR,—Last Tuesday, October 29th, was the centenary of Keats' birthday, and on that occasion the relics belonging to Sir Charles Dilke were displayed at the Chelsea Free Library, and some at the possessor's own house. I was fortunate in being able to examine some of these, and thus enabled to make a few additions and alterations in the short notice of Keats which I wrote in the Biographical History of Guy's Hospital, thinking that some of those who possess this book might like to do the same. I send you my few notes.

Amongst the relics is a note book, containing the name of John Keats, but no date. There is no mention of the origin of these notes, but they are evidently the commencement of a course of lectures on anatomy and physiology, the subjects being the bones, arteries and veins.

In my account of the poet I speak in doubt of his qualifications, but I find he had the diploma of the Apothecaries' Society, and by the courtesy of the late Dr. Semple, I have obtained the following extract from the Society's records. In the minute book of the Court of Examiners of the Society of Apothecaries, under date July 25th, 1816, occur the following passages:—"John Keats attended and produced testimonials to the satisfaction of the Court and was admitted to the Examination." "Mr. Keats was examined by Mr. Brande, and the Court granted him the certificate for which he had applied;" that is, to practise as an apothecary.

It may be noted that he was born at the "Swan and Hoop" livery stables, No. 28, Finsbury Pavement, and now a public-house; also that the name of the surgeon at Edmonton to whom he was apprenticed was Hammond. Previous to his residence in St. Thomas's Street, mentioned in my book, he lodged at No. 8, Dean Street, near to Mr. Cock's house. In writing to a friend in 1815, Keats says, "Although the Borough is a beastly place in dirt, turnings and windings, yet No. 8, Dean Street, is not difficult to find."

Although Keats was evidently industrious, and dressed for Mr. Lucas in 1816, his heart was not in his work, for in writing to a friend he said, "My last operation was the opening of a man's temporal artery; I did it with the utmost nicety, but reflecting on what passed through my mind at the time, my dexterity seemed a miracle and I never took up the lancet again;" and in speaking once more of his unfitness for the profession he said, "The other day during the lecture there came a sunbeam into the room and with it a whole troop of creatures floating in the ray and I was off with them to Oberon and fairyland."

It may not be altogether uninteresting to Guy's men to know that although Keats' mind was more inclined to the muses than to medicine, yet he would not have been an unworthy member of their Athletic Club. Cowden Clarke says that although he combined sweetness with the power of gentleness, yet when indignant under the influence of injustice, the form of his whole visage would change. The writer then tells the following story: "About this time Keats gave a signal example of his courage and stamina in the recorded instance of his pugilistic contest with a butcher boy. He told me in his characteristic manner of their passage of arms. The brute, he said, was tormenting a kitten, and he interfered; a threat offered, was enough for his mettle, and they set to. He thought he would be beaten, for the fellow was the taller and the stronger, but like an authentic pugilist, my young poet found that he had planted a blow which told upon his antagonist; in every succeeding round therefore (for they fought for nearly an hour) he never failed of returning to the weak point, and the contest ended in the hulk being led home."

At the age of 25 our young genius died. "Oh weep for Adonais."—Your obedient servant,

72, Grosvenor Street, SAMUEL WILKS.
November 3rd, 1895.

In the "Charity."

DEAR MR. EDITOR,—The continuous contraction of the uterus in labour is a very important subject, and has not fully received the attention it deserves in text-books, as Dr. G. Roper well remarks. And yet it is impossible to treat properly difficulties in labour without studying the various moods of the uterus in endeavouring to overcome the varying conditions of difficulty it meets with. Dissatisfied with the accounts I found in the text-books of that time, in 1867 I read a paper before the London Obstetrical Society (Vol. 9, Trans.), headed "On the Condition of the Uterus in Obstructed Labour, and an inquiry as to what is intended by the terms 'Cessation of Labour Pains,' 'Powerless Labour,' and 'Exhaustion,'" in which I showed that cessation of pains might be owing to two quite opposite conditions; one the merging of the rhythmical contractions of normal labour into the continuous form, and the other the simple subsidence of contractions either quite harmless or the effect of lesion of the uterine wall. The diagnosis of these different states I endeavoured to indicate so as to lead us to avoid the serious error of overlooking the outcoming of the formidable state of trismus, which is so insidious in its approach, and when once confirmed most difficult to overcome. Very shortly after this paper, when beginning in my lectures the division, "Difficult Labour," I gave a separate lecture on the lines of the paper above mentioned, and this afterwards was printed in the *Medical Times and Gazette*, now extinct. This I had printed in pamphlet form, presenting copies to many of the class, and again in 1888 I reprinted it, giving copies away to students. I have some by me still, of which I forward you one, and shall be pleased to send one to any student who would write to me.

With regard to the effect of chloroform in relieving the continuous action, my experience has shown me that if we are watchful, with the hand ready, there is a moment of relaxation in most cases, when we can just do what we want, but if we let that time slip, then we shall not have it repeated. But prevention is better than cure, and early delivery, as soon as the continuous action commences, is the safest treatment under chloroform.

I prefer the term "continuous action" to the terms "polarity," etc., as when once established the uterus is universally in action, and all polarity is lost, particularly in transverse and oblique presentations.—Yours, etc.,

J. BRAXTON HICKS, M.D., F.R.C.S.

Mr. G. De'Ath's Paper.

DEAR SIR,—I regret to see in the GAZETTE of October 26th a letter from a Mr. W. J. Johnson with comments on Mr. De'Ath's paper read on the opening night of the Physical Society. I am not learned in the ways of journalism, but I should certainly have felt that good taste did not allow criticism of that paper or any paper read under similar circumstances. Editorial leaders are all very well and in good taste, and there all remarks should end; many of us, no doubt, agree and disagree with Mr. De'Ath's paper, but, as a whole, it was a just exposition of what is professed, and I scarcely think Mr. Johnson's remarks called for or his personality desired. —Yours truly,

Cawdor House, J. B. JUDGE BALDWIN.
Rotherham.
November 6th, 1895.

Guy's Hospital Debating Society.

THE next meeting of the Debating Society will be held on Saturday, November 16th, at 7.30.

Mr. M. HAMBLIN SMITH will propose: "That the present system of Medical Education is in urgent need of reform."

Mr. E. A. Peters will oppose.

Obituary.

MR. THOMAS GROOME.

MR. THOMAS GROOME, who for 61 years was a medical practitioner at Whitchurch, Salop, and has just died at the advanced age of 84 years, was a member of an old Shropshire family, and first commenced the study of the medical profession by becoming an apprentice to the late Mr. Edward Gwynn, of Wem. He subsequently studied at Guy's and St. Thomas's Hospitals, at the same time attending the lectures at Grainger's, or the Grainger Street School of Anatomy. From thence he proceeded to Stevens' Hospital, Dublin, and in due time was admitted M.R.C.S. and L.S.A. London. In 1834 he commenced practice in Whitchurch, and for many years enjoyed the leading practice in the town and neighbourhood, obtaining to a large degree the confidence and support of the county families. He was beloved by a large circle of friends, and his cheerful disposition, never-failing fund of anecdote, and genial hospitality will long be remembered. In 1861 he was admitted an honorary F.R.C.S. Eng.

Soon after commencing practice he was called in to attend the wife of a labouring man, a primipara, forty-four years of age. After three days' attendance he was forced to the conclusion that nothing but craniotomy would effect delivery. He had no instruments at hand, but used for the purpose a large pair of scissors, with which he opened the head and forked out, according to his own statement, a teacupful of cerebral matter. The child was put on one side, apparently dead; but he said that at that moment his attention was concentrated on the mother. That child did not die, but lived, is married, and has a grown-up family. He is a well-to-do farmer, and to any medical man of his acquaintance he will show what he calls the "soft place in his head, owing to something which happened to him at birth." He is in possession of all his faculties, and has always enjoyed good health. This case affords an instance of the amount of injury that may be inflicted on the brain without interfering with the intellectual functions.

P.S.—If my memory serves me rightly, this case was mentioned in the early part of 1862, at a meeting of the Obstetrical Society, by Mr. A. P. Norton, of Harley Street, a friend of the deceased practitioner.

Guy's Hospital Auxiliaries' Mess.

THE committee wish to draw the attention of all Guy's men, and especially members of the Auxiliary Forces, to the above annual fixture, which will take place at the Guildhall Tavern, Gresham Street, E.C., on Wednesday, 25th November. Surgeon-Major R. Clement Lucas has kindly consented to take the chair, and will be supported by several members of the Staff. An excellent musical programme has been arranged. The committee earnestly hope that all members and friends will, by their presence, assist in making the evening, as on previous occasions, a great success. Tickets, price 3s. 6d. each, may be obtained from any of the members of the committee, or from the honorary secretary, G. H. Bedford.

Pass List.

Final Conjoint Examination, October, 1895.

MEDICINE AND SURGERY.

Poole, T. Brice — Spon, H. J.
* Tyson, W.

MEDICINE AND MIDWIFERY.

* Hora, J.

SURGERY AND MIDWIFERY.

Fort, H. R. T. — Pearse, A. S. J.
Stead, C. C.

MEDICINE ONLY.

Butler, A. G. — Huckle, A. H. H.
* Hearnden, H. — Jenkins, C. C.
Henson, W. W. — * Loud, F.
* Hewetson, H. — Muriel, G. B.

SURGERY ONLY.

* Ashwin, R. H. — Moon, R. O.
* Carden, W. A. — Reynolds, L. G.
Graham, S. G. — Roberts, E. S.
Haylett, P. H. — * Stuart, W. L.
* Wakefield, C. F.

MIDWIFERY ONLY.

* Clark, R. F. — * Lincoln, C. H. S.
Fulham-Turner, H. — Pendred, B. F.
Wood, W. R.

* Denotes completion of examination.

Calendar of Coming Events.

Nov. 9.—Surrey Cup. 1st XI. v. Kingston, at Kingston.
2nd XI. v. East Sheen Reserves, at Honor Oak Park.
1st XV. v. London Welsh, at Honor Oak Park.
A XV. v. Rovers, at Wandsworth.
Physical Society. Paper, "Heredity," P. Turner, B.Sc.

" 12.—Dental Society, 4.30. Paper on Cleft Palate, Mr. Heesom.

" 13.—1st XV. v. R.M.A., at Honor Oak Park.

" 14.—Christian Union. Address, Lt.-Gen. Brownlow.

" 16.—1st XV. v. Wickham Park, at Honor Oak Park.
2nd XV. v. Beckenham, at Beckenham.
1st XI. v. Eastbourne, at Eastbourne.
Debating Society, at 7.30.

" 20.—Mess Dinner and Smoking Concert at Guildhall Tavern.

" 21.—Christian Union. Address, "Religion in the Medical Profession," Rev. A. B. Boyd Carpenter.

Passim.

We trust that a large concourse of Guy's men will journey to-day to Kingston, where our Association Team are opposed to the local eleven. A few stimulating cheers on occasions like this make a lot of difference, especially towards the end of the game; and, moreover, the recent performances of the team indicate that their efforts should be both interesting and instructive.

We regret that we have not been supplied with details as to the proceedings of the Physical Society at the Clinical Evening on the 19th ultimo. We hear that the meeting was, fortunately, free from the scrambling, unmethodical character of its predecessors, and that the oratorical efforts showed some attempt at preparation of detail. The next assembly is held to-night, in the Smoking Room, when Mr. P. Turner, B.Sc., will read his paper on "Heredity." This should form a fitting sequel to the paper we present to-day on "Life and Death;" both well represent the modern tendencies of thought, yet we are ever in hopes that before the blessed diploma is handed to us, and we are bowed out of our Alma Mater, the Physical Society papers may take a somewhat simpler and antique turn, taking the practical view of the above theories and discussing the "Dietary and Treatment of Infants," or some subject equally obscure to the majority of students.

Mr. E. A. Peters is to be congratulated on his pluck in having stepped into the breach to oppose the motion at the Debating Society—"That Medical Education is seriously in need of reform." We trust that lack of supporters on the opposition side will not rob what should be a very interesting debate—from an oratorical point of view—of an unusual measure of success.

Once more the artistic taste and skilful touch of Mr. Stanley Cock has been in requisition, and this time it is to herald forth the announcement of the Volunteers' Mess, to be held at the Guildhall Tavern, on the 21st. On this occasion the word "Mess" covers a multitude of enjoyments, for we are promised not only a satisfying dinner, but also an enchanting smoker. And all for three shillings and sixpence.

Football accidents have been of late very noticeable for their severity and frequency, and especially is our sympathy evoked, mingled with a sense of personal loss, in the case of Mr. T. L. Jackson, who, playing for the Old Leysians on the date of our last issue, fractured his right clavicle. We trust that our excellent half-back will be able again to take the field for us after Christmas.

This last misfortune, which well exemplifies a proverb, itself too chronic a "chestnut" even for the Gazette, cannot but have a deleterious effect on the fortunes of the Rugby XV., if it can be said to have any fortunes at all. Their recent performances of a bad beating by Newport and a narrow victory over East Sheen were put entirely in the shade by their defeat by Lennox, which in the memory of the oldest inhabitant, is "a thing they had never done before," to quote Mr. W. E. Robinson's latest comicality.

During our extended stay at Guy's we have been to many Smokers, but we do not remember—of course our memory of some such occasions may be hazy—one to excel that presided over by Mr. H. A. Munro last Saturday, for it was peerless both in dramatic power and general *bonhomie*. Perhaps the most pleasing and satisfactory point of the whole concern was the subscription of £4 10s. by those present towards the Sustentation Fund, which shows that even in their pleasures Guy's men are mindful of the Institution to which they are proud to owe their livelihood, and will serve merely as an example of the much greater efforts to be made by the niggers and the students in general during the coming winter.

The second issue of the Magazine of the London School of Medicine for Women and

Royal Free Hospital is very pleasant reading, and fully upholds its motto, which, by-the-bye, adorns in solitude a whole page, "Work, as it is done." The invitation of the Lady Medicos to Guy's in May, at the meeting of the Debating Society, is gracefully commented on, and the whole journal is brimful of notes of general interest.

THE Testimonial to Pepper has taken the form of a handsome marble clock, of which, together with a small purse of gold, he was the recipient last week; beyond this, however, our late Porter has carried away the gratitude and friendly feeling of all Residents, past and present.

WE have received a letter addressed to the Secretary of the Guy's Hospital Chess Club from the same institution at "London," desiring matches with us during the present winter. This, following the letters in our last issues, should act as a further stimulus to those wishing to form a club amongst us, as this could be run practically without expenses, with the Reading-room chess-table always available. It now only remains for the energetic chess players to call a meeting in one of the Theatres to form a committee, etc., and pass rules, for which, and other negotiations, we should be happy to be the medium.

WE are asked to state, for the information of the Dental Students at this Hospital, that the papers set at the recent Dental Prize Examinations are being bound in book form for the convenience of those gentlemen who intend to compete next year, and that they will be ready for distribution at an early date.

AT a recent meeting of the Hunterian Society, Dr. Sims Woodhead gave an interesting *résumé* of the present state of knowledge on the value of antitoxic serum in the treatment of diphtheria and other specific infectious diseases. He pointed out that the main facts regarding its efficacy as a therapeutic agent were now accepted by all, except the wilfully ignorant or woefully obtuse. There were, however, certain obvious limits to its applicability, some of which would soon be overcome. He showed that it failed in some cases of diphtheria, because the severity of the initial poison so paralysed the tissues, that they were unable to react to the antitoxin. Further, there was good evidence to prove that its administration was of undoubted value, and even in cases that required tracheotomy.

Smoking Concert.

THE first of the series of Winter Smokers was brought to a very successful issue on Saturday last. Never has there been such a full house, and seldom a better programme. To Mr. Munro we are indebted for the labour of compiling the "Mammoth Bill," and to such a length was the programme carried, that practically no encores were possible. It is pleasing to note that with one exception, all the performers were Guy's men. We regretted that Messrs. Allport, Morton and Layman were unable to be present, but were pleased to see their places so well occupied by fresh talent; however, we hope to see them at our next concert. We must not forget to thank Mr. Stanley Cock for his share in the success of the evening; none could have viewed his posters without being incited to attend. Our old favourites—Messrs. Lulham, Coulson and Robinson—were as brilliant as ever, but where such varied excellence was shown, it would be invidious to draw further distinctions, so we briefly append the programme:—

PART I.—Pianoforte Duet, Messrs. Lidderdale and Hardenberg. Song, "To Althæa," Mr. R. E. Delbruck. Guitar Song, Mr. G. Rothe. Song, "A thing he had never done before," Mr. W. E. Robinson. Song, "The case of Obedient Mary," Mr. A. Miller. Violin Solo, Selections "Shop Girl," Mr. B. F. Henry. Song, "The Equatorial Line," Mr. F. H. L. Cloud. Musical Sketch, "Our Country Cousin," Mr. Lulham. Song, "A Finland love story," Mr. L. E. Handson. Guitar Song, Mr. G. Rothe. Song, "Fetters of Gold," Mr. J. Coulson. Song, "Our Court Ball," Mr. W. R. Cazenove. Song, "A May Morning," Mr. C. E. Michael.

PART II.—Song, "Skye Boat Song," Mr. R. M. Barron Banjo Duet, Messrs. F. H. L. Cloud and C. E. Michael. Song, "The Holy City," Mr. Morley. Song, "It touches the Spot," Mr. A. Miller. Song, "Ich Liebe Dich," Mr. L. E. Handson. Musical Sketch, "His experiences abroad," Mr. Lulham. Violin Solo (selected), Mr. Fortescue-Brickdale. Song, "Let me love thee," Mr. J. Coulson. Song, "For Me," Mr. E. G. W. Wallis. Duet with guitars (selected), Messrs. Fernandez and G. Rothe. Song, Mr. W. R. Cazenove. Song, Mr. E. G. W. Wallis. "God Save the Queen," Mr. F. J. Lidderdale.

We were sorry to see so few of the Staff present, but doubtless some were hidden in the dense cloud of smoke which enveloped everything towards the close of the entertainment. A new departure was made in handing round a collecting-box in aid of the Sustentation Fund, by which means £4 10s. was added to the funds of the Hospital.

Life and Death.

A Paper read before the Physical Society on October 12th, by Mr. R. Howard.

Mr. Chairman and Gentlemen,—Perhaps I ought to begin this evening by clearing myself from the obvious accusation of having attempted, in the choice of a title for my paper, to make a bad pun on the name of the gentleman who addressed us a fortnight ago; my defence must consist in pleading a *mental* alibi, by assuring you that my title was chosen before I knew anything about the arrangements for the inaugural meeting. Furthermore, I feel bound to offer some apology for venturing to bring before you at so early a date in the session, the subject of Death—one which would apparently be far better suited for the last than for the first meeting—but I trust that, if I am in any way successful in convincing you of what I believe to be the true meaning of death, and of its function in the scheme of Nature, you will allow that this incongruity is apparent rather than real.

Life and Death is undoubtedly a title which possesses the disadvantage of indefiniteness, but I have not been able to think of another which is less vague and yet sufficiently inclusive, and I believe that the one which I have chosen is that which best expresses the scope of my subject, for my endeavour this evening will be to put before you the purposes which death subserves, and the place which it holds in the scheme of living Nature.

A point of interest which should not be allowed to pass without mention, is that it was his essays on this subject that first brought Professor Weismann before the notice of English biologists, and further, starting from the consideration of the phenomena of life and death, he was led on, step by step, to the enunciation of that wonderful scheme of heredity around which nearly the whole of the biological investigation and controversy of the last ten years has been centred—a subject on which we are to have the pleasure of hearing a paper at one of the subsequent meetings of this session.

Turning now to consider the matter in detail, the first requisite is to have a clear conception of the sense in which we are to employ the terms *life* and *death*. A complete definition of life can scarcely be given, for we are as yet ignorant of its real nature, but it is nevertheless possible to make the meaning of the term clear by enumerating the attributes of living matter, and the phenomena, the observation of which enables us to state that any given thing is alive.

The characteristic phenomena of life are assimilation, movement, and reaction to external conditions. The living organism is able to build up into its own substance the matter it takes up from the world around it; it can turn the latent energy thus stored up into kinetic energy to move either its whole body or some part of it; and lastly, it is guided by impulses from outside which regulate its movements, and assist it in its search for food. When an organism which we have judged to be living ceases to exhibit these phenomena, when it ceases to assimilate, to move, or to react, we say that it has died. In short, *death* is *loss of life*. A word of caution must, however, be inserted here. Death is the irretrievable loss, and not merely the suspension of life; it does not follow that the mere cessation of the phenomena which we consider characteristic of life implies death; true death only occurs when the phenomena cease, never to be recommenced. Thus, an encysted protozoon or the seed of a plant are not dead, but simply in a condition of suspended animation, and the proof of it lies in the fact that they will again at some later date exhibit all the phenomena characteristic of living matter.

Next we must briefly consider the origin of life. Of the first beginning of matter we know nothing, but it is certain that it came into existence long before life. There was a time when the earth consisted of nothing but lifeless structures, ever acting in obedience to the immutable laws of motion, constantly absorbing the heat they received from the sun and then radiating it back into space. Then, on this realm of inanimate nature, when or how we know not, there appeared a substance which differed from the substance of the world around it in presenting those phenomena which we said above were characteristic of *living matter;* this substance was the primordial protoplasm, the source whence all living creatures on the earth have been developed. When we inquire more closely as to what is the difference between living protoplasm and the dead world around, we find that nothing new enters into its composition; all its constituent elements exist in inanimate structures, and indeed protoplasm can form itself—can build up living substance—out of dead material; hence, what separates animate matter from inanimate is not a difference in the constituents of which it is built up, but it must be some difference in the state of its atoms and molecules; in fact, it is more than probable that the secret of life lies hid in some special form of molecular motion, and when this motion ceases, life ceases with it. We must remember, however, that, though life continues, the actual living substance is perishable; waste and disintegration are constantly going on, but the mysterious form of motion continues, and endows the organism with the power of assimilation, enabling it to renew its substance as fast as it is used up.

We need not stop to discuss further the *form* in which living matter first appeared on the earth; suffice it to say that it was quite undifferentiated protoplasm, without cell-wall, without nucleus, but most probably containing chlorophyll or some analogous body. From this developed the two great kingdoms of animate nature, the plants which can, by virtue of their chlorophyll, convert the radiant energy of the sun into the potential energy of complex organic bodies, which are only in part used up in supplying their own needs; and the animals which, having lost their chlorophyll, have to find their energy in the stores laid up by the thrifty plant.

Having thus briefly considered the origin of life, we must now turn to investigate the origin of death. We have to ask, Is death a necessity? Did it appear on earth at the same time as life? Is there any inherent tendency in the form of motion in which lies the secret of life, which causes it, after a longer or shorter period, to come to rest? Perhaps to some such questions may seem absurd. We are so used to regard only the higher organisms where death *is* a necessity, that we are inclined to answer straight away that the tendency to death is inherent in life itself, and hence that the origin of death must have been coincident with that of life. This was, in fact, the statement made and accepted by all scientists till ten years ago, and to Professor Weismann is due the credit of having disproved this erroneous conception, and of having re-stated the facts in their true light. The conclusion to which he comes is that death is *not* a necessity; that the primitive organisms were *immortal*, and further that the unicellular organisms living on the earth at the present day have *retained their immortality;* while in the case of the higher organisms the tendency to death has been *secondarily acquired as a special adaptation.*

To us with our preconceived notions this idea seems so extraordinary that it requires careful consideration, but I think that a little investigation of the life history of the protozoa will show us that they really are potentially immortal.

Let us take an amœba for example: it goes on growing, and after a time divides into two precisely similar individuals; neither of these is mother or daughter, neither is older or younger than the other, they are exactly alike; each is a part, and an equal part of the original amœba. In like manner, each of the two amœbæ thus produced will grow and divide, and the process may be repeated *ad infinitum*, there is no inherent reason why it should stop; there is no such thing as natural death. Of course, I do not mean that no amœba ever dies, they are killed by millions, but then their death is *accidental* not *natural;* but they are *potentially* immortal, and if they do not meet with accidents will go on living and multiplying for ever. The life of every amœba at the present day has been passed on to it directly from the amœbæ which existed at the first dawn of life, and their life will be similarly passed on until the earth again becomes unfit for life to continue; or, to quote from Professor Weismann, "Each individual of any such unicellular species living on earth to-day is far older than mankind and is almost as old as life itself."

So much for the immortality of the protozoa. Turning now to the metazoa, we find a very different state of things; here there is no doubt that the popular conception of the necessity of death is correct; protect them how you will, every individual must die sooner or later; after two or three hundred years with an elephant, after two or three hours with a may-fly, death must inevitably occur; and this death will take place quite independently of any accident or injury, it is a true, natural death. If, then, in the course of the evolution of the metazoa out of the protozoa, death made its appearance, we have to ask first, How did it come about? and secondly, What purpose did it subserve?

The metazoa were probably evolved out of colonies of protozoa by a process of division of labour; differentiation of structure being associated with differentiation of function. During this process of evolution the primitive immortality of the cells was not lost entirely, but it persisted only in one group, viz.: in the *reproductive* cells, which, retaining to a great extent their primitive protoplasmic condition, were entrusted with the duty of passing on the life of the individual to its offspring; while the *somatic* cells took on various other functions, *e.g.*, motion, sensation, or secretion, and were differentiated accordingly. We thus see that immortality has, in a sense, remained with the metazoa, but only in a modified form. Life is handed on from parent to offspring through the medium of the reproductive cell, but the individual itself dies; or, as Johannes Müller ably put it more than fifty years ago, "Life maintains the appearance of immortality in the constant succession of similar individuals, while the individuals themselves pass away." I do not wish to imply that reproductive cells never die; of course if the individual is killed accidentally they perish with it; and further, when natural death occurs there are in the higher animals, many reproductive cells still remaining in the body, but in these cases death is forced on the reproductive cells by conditions external to them, it is not due to any inherent tendency in the cells themselves; their immortality is, like that of the protozoa, a *potential immortality.* Although, as above stated, the differentiation of the somatic cells coincided with the loss of their immortality, there was, so far as can be seen, no *à priori* necessity for this. It is conceivable that the bodies of the metazoa might have remained immortal. An amœba, although immortal, is able to move and feel and eat sufficiently well for its own needs, and it is quite conceivable that the muscular, nervous, and digestive tissues might have been quite sufficiently differentiated and yet have retained their immortality. If, then, the immortality of the individual might have been retained in the metazoa, why was it lost? How did death so benefit the species that it was acquired by the metazoa as a special adaptation? In short, what is the *use of death?* Its use is two-fold; firstly to get rid of worn out and damaged individuals, and secondly (by increasing the possible number of combinations between individuals), to give greater chance for the occurrence of favourable variations in the offspring, which may be developed by natural selection.

These two points require somewhat further elucidation. With regard to the first, it must be remembered that a protozoon, if it receives an injury, either dies or else recovers completely, while a metazoon can sustain very severe injuries and mutilations, such for instance, as the loss of a limb, and yet continue to live. If, then, there were metazoa which, though immortal, were nevertheless,

always liable to wear and tear, they would be constantly getting more and more scarred and damaged, until some accident more severe than usual, served as a final *coup de grace* to put an end to their miserable existence. Now, it would certainly be disadvantageous to the species to have such useless, mutilated individuals living on, and consuming the limited supply of food, and making the struggle for existence keener, and this disadvantage has been removed by the acquisition of the tendency to death. In the second place, it is evident that if the same individuals always lived on, inhabiting the same locality, there would be more chance of the same pairs being formed time after time, and so there would always be a tendency to similarity in the offspring. Now, on all principles of evolution by natural selection, with survival of the fittest, it is beneficial that the greatest number of congenital variations should occur, so as to provide a basis on which natural selection can act, and by developing those which are useful, favour the development of the species, and render it better suited to its surroundings. Death materially contributes to this desirable result, for, by constantly destroying the parents, it prevents the too frequent pairing of the same individuals, and favours combinations between the best adapted individuals of each successive generation.

Death, then, is *not* a primary attribute of living matter; it is *not* a necessary accompaniment of life itself; it must be regarded, not as the common foe of all animate nature, but rather as a function which has been *specially acquired* by the higher organisms, a function which, though it sacrifices the individual, yet does so in order to procure the advance and development of the species.

So much for the origin of death, and its use in the scheme of Nature. Now, a further question presents itself. Granted that death will eventually occur, what determines whether it shall take place sooner or later? In short, what regulates the *duration of life?* No one can study natural history without being struck with the great differences in the duration of life in different animals. An elephant lives about two hundred years, a sheep as many months, a mouse as many weeks, a wasp as many days, a butterfly as many hours, and a may-fly as many minutes. Many apparently plausible theories have been put forward in the past, which have for a time seemed to account for the facts, but which have in the end been found to be fallacious. Thus, *size* has been said to be the determining factor; and, indeed, it is easy to draw up a list of animals in which size and length of life decrease in corresponding ratio; but a pike or carp lives as long as an elephant, a toad as long as a horse, and a nightingale as long as a sheep; clearly size will not account for everything. Or again, it has been attributed to the degree of *activity* of the animal, to the rate at which it lives; it was supposed that an active animal lived out its life faster than a more sluggish one; but we find that the active birds and sluggish amphibians are both distinguished for their relatively long life, and so this theory will not hold water.

The true explanation lies in the fact that the duration of life is not determined solely by morphological or physiological considerations such as size or activity, but largely by a *process of natural selection* dependent on adaptation to circumstance; or, to quote Professor Weismann's words, "Duration of life is really dependent on adaptation to external conditions; its length, whether longer or shorter, is governed by the needs of the species, and is determined by precisely the same process of regulation as that by which the structure and function of an organism are adapted to its environment."

In any given case the length of life depends on two factors; first, the time required for the animal to reach maturity; secondly, the duration of the period of fertility. The former is partly determined by the morphological and physiological characteristics of the species (thus, a large animal takes longer to reach maturity than a small one; a complex, highly-developed one longer than a simple one); the latter, that is the period of adult life, is that which has its duration determined by adaptation to external conditions, that is to say, by natural selection. To a consideration of this process we must now turn.

As far as natural selection is concerned, the object of the life of each individual is to produce enough offspring to insure the perpetuation of the species; hence the only useful period is the period of reproduction; and thus we find that in the majority of animals, as for instance in most insects, life is not prolonged beyond the time of fertility. It is true that the birds and mammals, and, of course, man himself, form an exception to this rule; but here the prolongation of life after reproduction has ceased is obviously advantageous to the species, because these animals feed, protect, and teach their young, and it is a significant fact that in the few cases in which the life of insects is similarly prolonged, they perform a like function.

From the above facts it might at first sight appear that it would be advantageous to the species if the reproductive period of each individual were rendered as long as possible. This is, however, a wrong conclusion. The long life of the individual is of no special advantage to the species, what is beneficial is that it should have abundant offspring. Now, all animals are constantly exposed to sources of accidental death, from hunger, cold, epidemics, beasts of prey or parasites, and the longer that each individual lives the more it is exposed to such dangers; consequently, a short life, accompanied by rapid reproduction, is far more useful to the species than a long life with slow reproduction; hence it follows that the aim of natural selection is to render the period of reproduction as short, and the fertility as great as possible; in fact, we come to the somewhat surprising conclusion that Nature is constantly endeavouring not to lengthen, but to shorten life.

This may sound very paradoxical, but the facts show it to be true, at any rate in the majority of cases, and the more closely supposed exceptions are studied the more they prove to be only apparent. Let us begin by

examining one such difficulty. How are we to account on this theory for the long life of birds? A blackbird lives as much as eighteen years, and the smallest song birds about ten years. Why, if Nature is constantly trying to shorten life, has she not succeeded in this case? The answer is two-fold. In the first place, the offspring of birds are exposed to many dangers. The eggs are destroyed by crows, weasels, or jays; a little later similar enemies decimate the helpless young, later still enormous numbers die of cold and hunger in winter, or succumb during their migration to warmer climates. To make up for such wholesale destruction it is necessary that a very large number of young should be produced. In the second place, the fact that the structure of birds has been adapted for flight has precluded the possibility of any very rapid reproduction. Thus, some sea birds, *e.g.*, the guillemot, only lay one egg a year; many others, as, for instance, pigeons, only lay two; and many more only four or five, while those few birds of the gallinaceous tribe, such as the pheasant, or the jungle fowl, the ancestor of our domestic hen, which are capable of rapid reproduction, have acquired the power only by the sacrifice of much of their capacity for flight. In the case of birds, therefore, we find the necessity for a very numerous offspring, coupled with the physiological impossibility of producing that offspring very rapidly; plainly, the only way of achieving the result is to accord to the adult bird a relatively long life, and this is exactly what Nature has done.

The case of mammals, on the other hand, presents almost the exact converse; the intra-uterine development of the young, and the protection afforded them by their parents, renders them comparatively free from exposure to danger; while the rapidity of reproduction is, as everyone who has had any experience of rabbit-breeding will allow, very considerable. Hence Nature has been enabled to shorten the duration of mammalian life.

It is, however, in the insects that the shortening of adult life is most markedly shown. In their case the destruction of adult individuals is enormous, many animals being entirely dependent on them for their food, while the reproductive power is almost unlimited; in short, they present the most favourable opportunity imaginable for the operation of natural selection, and, if the principle enunciated above is true, their life should be of exceedingly short duration. This is, in fact, the case. Thus, a dragon-fly or a cockchafer, both long-lived insects, live a few weeks; a butterfly a few days; a may-fly only a few hours. The most extreme instance conceivable is reached in one of the may-flies (Palingenia), which never leaves its pupa skin to become a fly at all, but has acquired the power of pairing and reproduction in the so-called sub-imago state, or, to use a somewhat Irish expression, its life has been shortened so successfully that it never lives (in the adult state) at all.

An exception to this general rule of shortness of life in insects, which will probably have already occurred to many, is to be found in the ants and bees. It is true that the males live only a few weeks, but the workers and queens live two or three years—indeed, Sir John Lubbock has kept a queen ant alive for fifteen years. A little investigation will, however, show the reason of this exception. It was stated above that natural selection tends to shorten life on account of the risks to which the animal is exposed; such an argument, clearly, does not apply in the case of the queen bee or ant, who lives secure in a nest protected by the armies of her workers, and hence the longer she lives the more offspring she will produce, and the more she will benefit the species. The long life of the workers, also, is not surprising, for their only function is to work for the colony, and the longer they live the more work they will be enabled to do: on the other hand, the short life of the males is only natural, for after they have fertilized the queens they are of no further use to the colony.

One important point still remains for us to investigate. We have to inquire into the *process* by which natural death is brought about.

In a few cases death takes place quite suddenly: thus, most of the female lepidoptera die immediately after the eggs have been deposited, and the drone bee dies suddenly during the nuptial flight; in these cases death is probably due to a kind of nervous shock, the result in the one case of extreme exhaustion, and in the other of excessive excitement. Such a process is, however, quite exceptional, and it is only in the insects that it is found to any marked degree. In most cases natural death is a gradual process; the end may appear to come suddenly, but it is only the final act in a long chain of events, all having the same tendency.

It was stated above that the best and truest conception of *life* is obtained by investigating the lowest and most primitive organisms; in studying the process of *death* the exact converse is the case, it is best exemplified and has been most investigated in the highest organisms, and indeed in man himself. A little thought will show that this is likely to be the case; for if death is absent from among the lowest animals, and has been acquired by the higher animals during their evolution, it is natural to look to the end of the chain of development, that is, to man, to find the process in its most typical form.

We have then to inquire what that process is which gives rise to the condition known as senility, and which leads to natural death, or as it is popularly called, death from old age. With advancing years certain alterations take place in the tissues by which functional activity is diminished; these changes steadily increase, and finally, either themselves directly lead to death, or cause it indirectly by rendering the individual incapable of resisting injuries due to external influences. In short, the process is one of gradual degeneration of the tissues of the body. These changes, however, do not proceed equally rapidly with all the tissues; the brunt of the

process may fall on one, while the others are comparatively little affected; hence senility, though always due to the same ultimate cause, viz., tissue degeneration, may take many forms and lead on to death in many ways. Thus, the arteries may be, and frequently are, most affected; and we have atheroma, with its various complications; or it may be the skin which fails in nutrition, giving rise to eczema; or the calcification of the bones may fail, causing a liability to fracture; or the cells of the cerebral cortex may become functionally disordered, with paralysis agitans as the result. Or again, the viscera may be affected, for instance, the lungs may lose their elasticity, and the bronchi become degenerated so that a slight bronchitis, which would have been of no danger forty years previously, may now cause death. What determines the special lines along which degeneration is to advance is often obscure, but what we do know is that the tendency is always there, and that something, either in the employment or in the previous manner of life, or possibly in the climate, has swayed the balance in one or another particular direction.

So much for the nature of the process; let us now consider the duration. How soon does degeneration set in? In other words, *at what age do we begin to die?* In answering this question it must be remembered that the process may have been going on for some time before the results become sufficiently obvious to be appreciated as a definite disease. It is universally acknowledged that by thirty it is becoming dangerous for a man to play football, and the reason given is that he is less active than he was, and consequently falls more heavily than before; that is to say, the muscles are already losing their elasticity, the bones are becoming more brittle, and the ligaments are getting less resistant—in fact, each tissue is losing its special characteristic. Surely this is rightly regarded as the first stage of degeneration. From henceforward the process, slowly it may be, but nevertheless surely, advances, so that at forty not only is a game like football out of the question, but a slight twist or sprain, such as would scarcely have been noticed in early life, may cause a serious result, such for instance as a Pott's fracture; still, if accidents do not occur, the man may be considered in perfect health, and it may not be till fifty, or sixty, or even seventy or eighty that the senile changes are sufficiently obvious to constitute a disease.

Death, then, may be said to begin almost as soon as development is complete. Scarcely has the last epiphysis united before loss of activity gives the warning of the more severe degenerative processes to follow. In short, life consists of but two processes, *growth* and *decay*. The perfectly developed individual is an ideal which, if ever realized, endures but for a moment; gradually are the tissues built up and matured till they form what may for a time appear to be a perfect whole, but as soon as development is complete, surely and effectually does degeneration set in. Early manhood is but the last step in development; the prime of life but the first stage of decay. When we contemplate these two mutually antagonistic processes, which succeed one another in life with scarcely any appreciable interval, it would appear as if Nature had been striving beyond her strength; she has put forth all her power to develope an organism which shall, both in structure and function, satisfy her ideal, but the mechanism is too complicated, the adjustments are too fine, almost as soon as it is completed it begins to get out of order, and gradually it breaks down, until it finally comes to a standstill in death.

Finally, it might be well briefly to summarise the points which have been put forward this evening.

We have seen that the ordinary idea that life carries with it the necessity for death is erroneous; when life first appeared, death was non-existent; the first living organisms were immortal; and further, the protozoa of the present day still retain their immortality, and each individual now alive, may be said to be as old as the species.

Death first made its appearance when the colonies of protozoa became differentiated to form more complicated individuals; it was, however, not a necessary consequence of this differentiation, but it was acquired for the benefit of the species. In a sense, Nature had to choose between immortality with stagnation, and death with development; she chose the latter, preferring to sacrifice the individual for the sake of the species, rather than to abandon the species for the sake of the individual.

Passing on from the origin and function of death, we considered the factors which determined the duration of life; we saw that the length of life was very various in different animals, and that in each case, it was determined largely by an adaptation to external conditions, brought about by natural selection, and further, that since a long life exposes the individual to more dangers from external foes than a short one, it follows that Nature is constantly endeavouring not to lengthen life, but to shorten it, at the same time increasing reproductive activity as much as possible.

Lastly, the process of death has been considered. We saw that it was due to the gradual degeneration of tissue, and, further, that the first signs of this degeneration appear almost as soon as the body is fully developed, so that life consists of the succession of two opposite processes—growth and decay. Slowly does the individual climb up the hill of development; arrived at the summit, he remains scarcely long enough to take a glance round before he begins to slip, at first slowly, but with ever-increasing velocity, down the slope of degeneration.

In conclusion, I have to thank you for your kind attention this evening, and for the honour you have conferred upon me, by permitting me to read a paper before this Society. I have tried—I trust not entirely unsuccessfully—to put before you death in a different light to that in which we commonly regard it, viz., as a great factor in development! It is, perhaps, encouraging to think that we die that the race may advance; that our death may make room for our more perfectly developed and equipped descendants; in short, that we

all die for the sake of mankind! And now, I can only express the hope that the death of my paper may make way for others to follow, as immeasurably superior to mine as a human being transcends a protozoon.

Case of Mandibular Fracture.

On April 23rd, I was asked to see a patient admitted into Guy's Hospital on the previous day, under the care of Mr. Davies-Colley. There was oblique fracture in the median line, with great displacement of the right side downwards and inwards. The patient denied that he was under the influence of alcohol when the accident happened, and it is probable that the fracture occurred during an epileptic fit. The displacement could be reduced, but firm pressure was necessary to maintain the fragments in correct position. Under such conditions the use of the Hammond wire splint is unsuitable, for the wire bends, or the teeth loosen, and the result is a failure. In most cases of firm displacement the upper jaw should be used as the fixed point of attachment, and the splint should be made with inclined planes along which the fragments of the broken bone can be drawn into position by means of a submental bandage. To accomplish this object I made a modification of Gunning's splint, which was inserted four days after the accident. Next day I was summoned to the Hospital, and found that the splint had been removed and the displacement was growing firmer. The patient had removed the splint in order to eat his dinner, and could not re-apply it. During the night he had been very restless and troublesome, and it was almost necessary to place him under control. Had this man left the Hospital immediately after the application of the splint, as many others have done, we should have lost sight of him for a time, during which fibrous union would have taken place, fixing the fragments and perpetuating the deformity. The proper treatment is to keep the patient in bed, lying on his back in a semi-recumbent position until some degree of union has occurred; the chin should be depressed upon the chest, for in this position the muscles that act on the lower fragment are relaxed. This course was adopted, but the patient persevered in removing his splint. On April 29th he had an epileptic fit in the night.

To fix the fragments firmly I made a splint known as Tome's modification of Mutter's clamp, consisting of a silver cap, lined with gutta percha, covering the teeth and gums of the lower jaw; leaving the line of fracture free in front for drainage. The splint should be warmed over a spirit lamp before insertion, and the surface of the gutta percha should be moistened with oil of cajeput, which is a powerful solvent of gutta percha, and makes it adhere to the teeth very firmly.

I explained to the patient that if he again removed his splint a surgical operation would be necessary, and I gave him a detailed description of the operation for uniting a fractured jaw by wire sutures passed through the bone. His conduct now became exemplary for a week, but he was kept in the Hospital as a precautionary measure. On the eighth day he resumed the practice of removing his splint. I then decided to make a plate that could be secured with wire sutures to the teeth, and Mr. Cave, the Dental House-Surgeon, made a metal splint that covered the lingual surface of the jaw and the masticating surface of the teeth. Opposite the necks of several teeth, spaces were made in the plate for the passage of the binding wires. This splint was affixed on May 17th, and although some of the wires had to be replaced the splint was not removed.

On May 25th the patient suddenly left the ward, owing to his aggressive conduct towards one of the other patients, but he attended from time to time in the Conservation-room, and by the middle of July union was sufficiently firm to have justified removal of the splint in any ordinary case, but I thought it prudent to wait for one more month. During my absence in August the splint was removed; the union was found to be complete, and the line of the teeth was fairly satisfactory.

F. NEWLAND-PEDLEY.

Reviews.

Medical Electricity. By Dr. Lewis Jones. Second edition. Crown 8vo. (London: H. K. Lewis.) Price 7s. 6d.

This is a practical hand-book for students and practitioners, written by the medical officer in charge of the electrical department in St. Bartholomew's Hospital. It appears from the preface that the favourable reception accorded to the first edition leads the author to hope that the value of electricity as a mode of treatment is becoming more widely appreciated in this country. At the present moment medical electricity is firmly established as a therapeutic agent in America and on the Continent, but in Great Britain the subject is too often viewed with coldness or utterly ignored. No doubt the difficulties and expense connected with the management of electrical apparatus is largely responsible for this state of affairs.

The first five chapters of about 180 pages are devoted to technical details of currents and batteries; they are well illustrated and the descriptions made as simple as possible. The physiological effects of electricity on muscle and nerve, the resistance of the tissues, and the diffusion of currents are then shortly stated. This is followed by an important chapter on diagnosis by the electric current, and here we find the terms Faradism, Galvanism, &c., replaced by the phrases "treatment by induction coil" or "by the battery." The remaining seven chapters, some 200 pages, are devoted to the consideration of the therapeutic uses of electricity and its mode of application. The details of treatment are

for the most part clearly given, especially in regard to such common affections as infantile paralysis, neuralgia, and cutaneous nævi. Under the heading of Nerve Lesions some interesting examples of muscle-palsies are described and illustrated by photographs. The writer points out a fresh diagnostic sign of atrophy of the trapezius, viz., when the patient is told to raise the arms to the head the outer half of the clavicle comes into view from behind on the paralysed side.

The tone of the book is hopeful, but not too enthusiastic. We have no hesitation in strongly recommending its perusal.

Dental Materia Medica and Therapeutics. By James Stocken, L.D.S. Revised by Leslie Stocken and J. O. Butcher. Fcap. 8vo. (London: H. K. Lewis.) Price 3s.

This is the fourth edition of a little volume originally published in 1877. It has been thoroughly revised and re-arranged, while the introductory remarks on pharmacy and pharmacology have been almost entirely re-written. In its present form the book will be found very handy and helpful by those to whom it is addressed. As the information is derived from the recognised authorities, we have the best guarantee of its accuracy. The list of drugs which constitutes the dental materia medica is certainly a long one, but the selection has been made with care. Under the heading of Nitrous Oxide there is an interesting account of its history and physiological effects. A useful therapeutic index, notes on the modes of performing artificial respiration, and a list of abbreviations used in writing prescriptions, make up a volume which cannot fail to supply the requirements of those studying for the dental qualifications or commencing practice for themselves.

Elements of Practical Medicine. By Dr. A. H. Carter. Seventh edition. Crown 8vo. (London: H. K. Lewis.) Price 7s. 6d.

The fact that "little Carter" has lived through seven editions, and not only lived but grown, is good evidence that it has well supplied the journalists' "long-felt want." Moreover, when a book has been before the medical public for fifteen years, and six large editions of it have been successively exhausted, there is little need for criticism and less for recommendation. The author's object has been to provide broad sketches in bold outlines of the various types of disease, rather than a birds-eye view of "Fagge." In this he has succeeded, and consequently the book is both easy and pleasant reading, eminently suited for the student who is making his first acquaintance with disease in the medical wards, and for him of riper years who wishes to refresh his memory rapidly before presenting himself at the College or the Hall. We note that diseases of the skin form a separate section, which is contributed by other well-known hands. The therapeutic index, which occupies thirty pages at the end of the book, will probably be the most useful section when the examinations are passed and forgotten.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

M., KIDDERMINSTER.—The growth has the structure of a squamous-celled epithelioma.

J. H. P., BAMPTON.—Tubercle bacilli are present in the sputum in fairly large numbers.

G. J. W. F., YEOVIL.—No tubercle bacilli could be detected in this specimen of urine.

F. R. B. B., TUNBRIDGE WELLS.—Tubercle bacilli are present in the sputum in enormous numbers.

W. G. M., FETTER LANE.—Microscopic examination of the membrane showed the presence of numerous cocci, arranged as streptococci, and a long, thick bacillus, but nothing resembling the diphtheria bacillus. After twenty-four hours' incubation on blood serum a growth had taken place, which, microscopically, consisted of cocci, arranged as streptococci. No Klebs-Löffler bacilli could be detected.

PATHOLOGIST.

Appointments.

BEVAN, RICHARD, L.R.C.P. Lond., M.R.C.S. Eng., has been re-appointed Medical Officer for the No. 1 District of the Romney Marsh Rural District.

DALGLISH, RICHARD R., M.R.C.S. Eng., L.S.A., has been re-appointed Medical Officer for the Brooklane District and the Workhouse of the Romney Marsh Rural District.

MILNE, J. B., M.B., C.M. Aberd., has been appointed Honorary Medical Officer to the Sheffield Children's Hospital, *vice* Cleaver, deceased.

RANDELL, R. M. HENRY, M.D. Lond., M.R.C.S. Eng., has been appointed Honorary Medical Officer to the Beckenham Cottage Hospital.

Sport.

Association Football.

GUY'S v. BECKENHAM.

Played at Beckenham on Saturday, October 26th. From the kick off our forwards got away, and Ford shot wide. For the first quarter of an hour we had all the best of the game, but could do nothing, the state of the ground making accurate shooting a matter of considerable difficulty. Humphrey and Ford were conspicuous for one or two good runs on their wing. From a pass by Walker, Palmer and Mandy got up, the latter passing back to Hall, who scored the first goal with a good shot, the ball striking the crossbar and rebounding off Bolus into the net. After this the game was more even. Just before half-time the Beckenham right got possession and scored their only goal. In the second half the game became much faster, and our combination better. The Beckenham right half played up wonderfully, and Humphrey and Ford, who kept much too close together, had plenty to do. Walker was playing a sterling game, and eventually Ford scored with a good low shot; their forwards were now prominent, and "hands" close to the goal line was given against us, but came to nothing, and the game ended in our favour by two goals to one.

The combination of the forwards was a great improvement on the previous game, but we were unfortunate in front of goal. Ford should keep the ball more when no one is near, and not pass so wildly. Walker, as usual, was invaluable, and did some brilliant things. Thornely played a hard game, but lacks pace to make a good half-back. Barker very kindly entertained us after the match, and we spent a most enjoyable time until train-time. Team:—

Guy's.—H. M. Barker (goal); E. A. Longhurst, G. Marshall (backs); R. W. Hall, F. E. Walker, M. H. Thornely (half-backs); P. S. Mandy, W. G. Palmer, A. Pearson, G. Ford, L. Humphrey (forwards).

GUY'S v. ST. MARGARET'S-ON-THAMES.

Played at Honor Oak Park, on Saturday, November 2, resulting in an easy victory for Guy's by five goals (Palmer 3, Humphrey 2) to love. During the first half play was of a very even character, there being little or no combination amongst our forwards, who, with the exception of Humphrey, did not seem to be in a mood to exert themselves. After twenty minutes' play, Palmer scored a lucky gaol, the ball hitting the crossbar and going into the net off one of the opposing backs; Humphrey then made a beautiful single-handed run half the length of the ground, and wound up by placing us two points ahead, by which number we led at half-time. On re-starting, our forwards, as is their wont, put more life into the game, after their long rest; but the passing was very wild, and after some fruitless shots at goal Palmer at length broke the spell and scored with a beauty. The same player shortly afterwards added another after a shot from Humphrey, which rebounded from one of the uprights; but the latter made up for this by placing a second to his credit immediately after. On time being called, we were left winners, as stated above. Barker, Humphrey and Palmer were the pick, and we are glad to see that the latter is at last showing some of his true form, his shooting being a great improvement on some previous performances. The back division, as a whole, played a very fair game, though there were a good many miskicks among the backs; and Hall must remember that he has an inside wing man to feed as well as an outside. Team:—

Guy's.—H. M. Barker (goal); G. Marshall and E. A. Longhurst (backs); R. W. Hall, F. E. Walker and H. A. Higgens (half-backs); P. S. Mandy, W. G. Palmer, A. Pearson, G. Ford and L. Humphrey (forwards).

As the Surrey Cup first round is played to-day, a few words of advice here would not be amiss. The forwards must play up hard the whole game, and not take short intervals of rest at various periods. Also, both half-backs and forwards must mark their men when it is our opponents' throw-in from touch. The backs must mark their inside wings better than they have done up to the present, and also make sure of their kicks.

GUY'S 2ND XI. v. BECKENHAM 2ND XI.

Played at Honor Oak Park on Saturday, October 26th. During the first half, Guy's had decidedly the best of the game, and ought to have scored several times, but the shooting of the forwards was very poor, the ball nearly always going wide of the goal. After twenty minutes' play, Barron scored the only goal for Guy's from a corner kick by Higgens.

After changing ends, Brookhouse came into inside left, changing places with Barron, and the combination amongst the forwards was a little better. The game was much faster than during the first half, and Beckenham scored an easy goal, through the ball being so slippery, and Thomas not being able to pick it up. The pace now began to tell on our men, and Beckenham claiming a free kick just before the call of time, scored their second goal, thus winning by two goals to one. The halves played well throughout the game, and Matthews at back was good. Butler would be much better if he would only learn to keep his own place. Team:—

Guy's.—A. R. Thomas (goal); J. Matthews, C. Miles (backs); H. A. Higgens, H. A. G. Butler, H. R. Marsh (halves); C. S. Brookhouse, R. M. Barron (left wing); E. T. Davies (centre); A. A. Miller (capt.), A. M. Kemp (right wing), (forwards).

GUY'S 2ND XI. v. ST. THOMAS'S 2ND XI.

This game was decided at Honor Oak Park on Wednesday, October 30th, resulting in an easy win for Guy's by six goals to two. On starting, the game was pretty

even, but Guy's soon showed their superiority by scoring two goals closely following one another, which were kicked by Davis and Pearson. St. Thomas's soon after scored their first goal from a free kick in front of the posts. The combination among the forwards was very good at times, and from some good passing Brookhouse and Pearson were enabled to score the next two goals before the whistle sounded for half time.

St. Thomas's on re-starting the ball seemed determined to score and continually pressed, but only managed to add one more goal to their score, through our backs playing a steady defensive game and gradually turning them out; later, Guy's had matters pretty well their own way again, but Thomas managed to save a very brilliant shot during a temporary assault by St. Thomas's. Nothing more exciting happened before the call of time, the remaining two goals being scored by Davis and Humphrey. The team played well together with the exception of Butler, who hardly ever seemed to know whether a man near him was on his own side or an opponent. Special mention ought to be made of Hall, who played a pretty game throughout, and Humphrey was decidedly the pick of the forwards. Team:—

GUY'S.—A. R. Thomas (goal); J. Matthews and W. H. M. Smith (backs); R. W. B. Hall (captain), H. A. G. Butler and H. A. Higgens (halves); C. S. Brookhouse, A. Pearson, E. T. Davis, A. A. Miller and L. Humphrey (forwards).

GUY'S 2ND XI. v. R.M.A. 2ND XI.

Played at Woolwich on Saturday, November 2nd, resulting in a win for the R.M.A. by four goals to two. The R.M.A. scored two of their goals from free kicks, one being a penalty. The goals for Guy's were kicked by Davis and Miller. Guy's were rather weak in the back division, with the exception of Thornely and Smith. The forwards played fairly well together, but Kemp found himself continually on the right side instead of the left; and Edey ought to learn to pass into the centre before he gets too near the goal-line. Team:—

GUY'S.—G. Shorland (goal); W. H. M. Smith and H. A. Butler (backs); M. Thornely, A. R. Thomas, D. S. Greenfield (half-backs); R. G. Edey, A. A. Miller (captain), E. T. Davis, A. M. Kemp and C. S. Brookhouse (forwards).

Rugby Football.

CARDIFF v. GUY'S AND ST. THOMAS'S HOSPITALS.

The Cardiff team, with only one change from that which drew with Newport, opposed the team composed of players selected from Guy's and St. Thomas's Hospitals, at the Cardiff Arms Park, on Saturday afternoon. The game was looked upon as likely to prove interesting, The visiting team was as follows:—

HOSPITALS.—Moggridge (back); Brown, Greg, F. C. Wetherell, and Sime (three-quarter backs); Rotherham and J. N. Gardiner (half-backs); Bingham, Gilbert, Dominy, R. S. Thorpe, Nelson, E. G. Goddard, W. P. Gwynn, and W. Tyson (forwards).

Referee: Mr. R. Garrett, Penarth F. C.

Exactly to time the Cardiff team entered the field, closely followed by the United Hospitals. There were about 6,000 spectators present. The weather was rather dull. The Hospitals kicked off, and the ball was well returned to the visitors' half. The Medicos returned to half-way, but were not stopped there, they taking the ball on to the home twenty-five. Cardiff came away, and got to the visitors' twenty-five, where the homesters had a "free." A trial for goal resulted in a minor. The Londoners dropped out, and play was taken to half-way. Some nice play was here witnessed by Nicholls and Biggs, they taking the ball to the visitors' line. From a pass Norman Biggs ran, and, when tackled, threw the ball to the forwards. Owing to bad play on the part of the home men, the Medicos found their way to the Cardiff twenty-five; but the Cardiff forwards, getting the ball, managed by good passing to reach the visitors' half. From a kick by Norman Biggs, one of the visitors made his mark, but nothing came of it. The home "ups" broke away, but were stopped by a forward pass. Shortly after, the Londoners, by hard work, again got to the Cardiff twenty-five, where their onward progress was stopped by Alun Morgan. In the Cardiff twenty-five, one of the visiting halves picked up from the outskirts of a scrum, and ran strongly. He gave up to his right centre three-quarter, who, feinting to pass, dodged through his men, and passed to Greg, who ran round behind the posts, amid loud cheering. From the place-kick, a beautiful goal resulted. Cardiff re-started from half-way, and play was kept in the Londoners' half. The home three-quarters tried hard to get through, but were repeatedly stopped by deadly tackling of the opposing men. Just after, Norman Biggs tried to "bash" through, but was grassed quickly: Sweet-Escott dropped for goal, but the shot went wide, only a minor resulting. The visitors dropped out, and got to half-way, where Elliott picked up and kicked to touch, from a scrum Elliott again received from Sweet-Escott, and gave up to Nicholls, who looked like going through, but was splendidly tackled. From a kick Alun Morgan ran, and returned over the visitors' line, exacting a minor. On the drop-out, the Medicos worked on to half-way, where Norman Biggs had a kick charged down. Escott ran down the field, and turned the ball into touch. The whistle was then blown for half-time. Half-time score:—

UNITED HOSPITALS—1 goal.

CARDIFF—3 minors.

After lemon time, Cardiff restarted the oval, and one of the visiting three-quarters mulling, he was tackled with the ball in his possession. A scrum followed, after which a pretty round of passing by the Cardiff backs was witnessed, Hussey nearly getting over. Another hot attack on the visitors' line ended in Williams nearly

scoring. The homesters were not to be denied, and another grand round of passing was seen, Escott passing to Williams, who gave up to Biggs, who, sprinting grandly, scored a wide try: Norman, taking the place, made a miserable attempt at goal. Just after the drop-out, Escott got away from a scrum, and chucked to Biggs, who, again running strongly, got right round his opponents, and planted the ball beneath the posts. The place kick again failed. On the drop-out Cardiff again attacked fiercely, and in the last pass Williams, when tackled, did Pearson's trick of punting over his opponents, but was not sharp enough to get the ball again. From the corner flag the ball was sent out to the third line, which ended in Norman Biggs again scoring another wide try. Again he failed in the attempt for goal. Soon after the drop-out, one of the visitors, intercepting a pass, broke away and dribbled down to Alun Morgan, whom he grassed on the centre line. Mills got away from the centre, but failed to pass when tackled. Cardiff again attacked the Londoners line, and exacted a minor. From the drop-out Alun Morgan took the oval, and made a beautiful kick to the visitors' corner flag. Just after, the ball was again kicked across to the Medicos' line. From an exchange of kicks Elliott made his mark, but nothing resulted. Off-side play entitled Cardiff to a penalty kick, Elliott punting to the Hospitals' end. Norman Biggs dropped for goal, but only a minor resulted. On the drop-out the visitors worked to "no man's land." The Hospitals gained more ground by passing. A drop for goal on the visitors' part gave them a minor, Escott dropped out, and Cardiff relieved to half-way. From loose play the Cardiff forwards picked up, and it loked as if they had scored, but only a minor resulted. The Londoners got to the Cardiff line from the drop-out, and soon notched a minor. Time was then called. Final score:—

CARDIFF—3 tries, 7 minors (9 points).
UNITED HOSPITALS—1 goal, 2 minors (5 points).

NEWPORT v. GUY'S AND ST. THOMAS'S HOSPITALS.

THESE teams met at Newport on Monday afternoon, October 21st, both having experienced the adversity of a defeat on the previous Saturday. There were a number of alterations in the Newport team. The weather was anything but pleasant, rain commencing to fall at the time announced for the kick-off. There was not a big attendance. Team:—

HOSPITALS.—Moggridge (back); Hanbury, J. J. E. Biggs, F. C. Wetherell and F. Sime (three-quarter backs); Greg and J. N. Gardiner (half-backs); Bingham, Gilbert, Dominy, R. S. Thorpe, E. G. Goddard, W. P. Gwynn, W. Tyson and P. A. Dykes (forwards).

Referee: Mr. A. J. Davies, Cardiff.

The visitors having lost the toss kicked off at 3.20 towards the gymnasium end, and Pearson returned. A visitor mulled and Saunders started a round of passing which took play into the visitors' half. Here Pearson neglected to take a pass from Parfitt who had picked up, and the Newport men were driven back to neutral ground. A visitor made his mark, but Boucher took the ball on the kick and ran back and punted to Dauncey: Gus Gould mulled the next pass. Then Gus Gould and Dauncey ran and gained the visitors' half where Sime tumbled Dauncey into touch. The Medicos by means of a smart kick to touch got back near half-way, but the home forwards drove them back and a visitor who strove to get off was well tackled by Boucher. Then passing between the home quartette took the ball to the goal line where Gus Gould was called back for a forward pass. The visitors intercepting some loose passing, got out to the centre, where Parfitt came away grandly from a scrum, and made a beautiful opening for Pearson, who punted over the line, and sprinting up, scored in a favourable position, amid applause. Boucher landed the major point. The doctors restarted from the centre and Groves returned. Hanbury missed the ball, but Greg kicked back. Then Parfitt started another bout of passing at the centre, and Lloyd and Boucher having handled, the latter passed to Pearson, who repeated his dodge of punting over, following up and scoring. This time, however, the ball was grounded on the far side of the goal posts on the left and Boucher failed at goal. Bert Gould replied to the drop out and the home men were soon attacking again. Owing to some weak play by Gus Gould and Dauncey, the Hospitals men relieved to half-way. Parfitt again started a bout of passing, but Gus Gould after running straight across the field and passing to Pearson mulled the back transfer: Newport, however, got into their opponents' twenty-five. Owing to loose play, a visitor was making off but he knocked on: the whistle, however, was not heard, and R. Thomas saved by falling on the ball at the centre. From here Llewellyn Lloyd ran through and passed to Groves, but Wetherell intercepted. The visitors then worked back, but Llewellyn Lloyd dribbled down from a scrum, and trickily kicked across to Parfitt, who rushed over and scored at the end of the line. Boucher failed at goal. Biggs dropped out, and Bert Gould returning, Greg mulled, and after a little loose play in the visitors' half, Biggs had a kick which was charged down, and Llwellyn Lloyd picking up, ran in under the posts; Boucher landed another goal. R. Thomas replied to the kick-off, the ball landing into touch in the Newport half. From a scrum here, the visitors' backs got off with some lumbering, and Wetherell kicked into touch near the Newport line. Parfitt drove them out to the twenty-five with a kick. The visitors started passing, but their movements were so slow and ungainly as only to excite the hilarity of the crowd. The ball, however, was kicked to R. Thomas, who in running to get it, slipped: he recovered himself, however, and put in a punt to touch, which gained at least twenty-five yards. By this means Newport got over the division line. Here the forwards started passing and gained a lot of ground, but Ivor Johns made a mess of a good pass at the twenty-five. Then Parfitt, Lloyd and Gus Gould

handled the ball, and the latter, when hemmed, passed to Newcombe: he again unselfishly gave up with great judgment to Dauncey, who ran over at the end of the line. Boucher failed to majorise this time. On the drop-out play continued in the visitors' half. Here Parfitt threw a long pass to Gus Gould over Dauncey's head, but Gus, trying to round John Biggs at the centre, was finely collared by that individual. Just after Gus got a pass out from Llwellyn Lloyd and ran through the opposing centres. He passed to Dauncey, who ran over the line, but the ball was called back. Thus a grand bit of play was spoiled by a throw forward. The home three-quarters got off again, but Bert Gould gave a bad pass to Pearson, which it was impossible for him to accept, and Bert, who again picked up, was thrown into touch by Hanbury. Half-time score :—

NEWPORT—2 goals, 3 tries.

HOSPITALS—Nil.

On resuming, a lot of loose play was witnessed, the Hospitals' back being called upon twice. The last time they responded with a good kick, and Pearson making his mark off this, kicked to touch. The Hospitals got out to half-way, where the home forwards, headed by Sawtell, dribbled down the field. Parfitt made off from a scrum, and made a beautiful opening, but he was not well backed up, and his pass was not taken advantage of. Gus Gould sent a wide pass to Pearson, who could not get round, and Gus, who took Pearson's pass, was at once held. Lloyd obtained the ball from a scrum, and running right through the opposing backs, scored his second try, amid cries of "Good old Seconds." Boucher made a good attempt at goal but failed. J. Biggs dropped out. Bert Gould made a capital reply, and Gardiner mulling, Newport again penned their opponents. Lloyd gave a pass out from a scrum, but Dauncey failed to hold it. Parfitt, however, got off from a scrum, and passed to Pearson, who, by means of his favourite trick, scored again in an unfavourable position. The attempt at goal was again a failure. Biggs again dropped out, and Boucher taking the ball, ran, but his pass was a bad one. Lloyd, however, got clear from a scrum, and threw to Parfitt, and he handed on to Pearson, who failed in his endeavour to round his opponents. Then Pearson threw a wide pass to Dauncey, who made a good attempt to get round, but he was pulled down. Pearson kicked over the line, and the Hospitals' custodian kicked out of bounds. The exchanges after the drop-out left play in the Hospitals' half. The Hospitals' forwards rushed a scrum, however, and dribbled to the Newport half, where Lloyd threw to Gus Gould. He mulled, but picking up, kicked, and some exchanges left the ball at half-way. The visitors were again making headway, when Parfitt put in a lovely punt to touch, and the home forwards gained further ground. A visitor broke through, and a lot of loose play by the home backs was terminated by R. Thomas making the ball safe at the centre. Bert Gould taking a pass, kicked, but the Hospitals' back replied to touch with interest. Dauncey kicked back after a ridiculous knock-on by one of the visitors, and following up the Newport three-quarter gained a lot of ground owing to a mull by the visitors full back. By some lucky play the visitors got into the home twenty-five, but the black-and-amber forwards responded with a fine dribble. The Londoners now made strenuous attempts to score, not being at all particular how they knocked on. Pearson at length drove them back by dribbling out to half-way, where Lloyd came away and passed wide to Bert Gould, who passed to Gus Gould, but he mulled badly, and a slight delay occurred owing to an injury to Gardiner. He resumed playing, however, and Newport, with only a few minutes to play, started a hot attack. The Medicos, however, defended better, and a good kick out by Greg drove Newport back to nearly half-way. Lloyd here passed out to Parfitt, who cleared a couple of men, and passed to Gus Gould, who again fumbled, and R. Thomas was called upon to save, which he did. A visitor, who would not be held, had his jersey torn off, and was grounded. Time was then called. Final score :—

NEWPORT, 2 goals, 5 tries, 1 minor.

HOSPITALS, nil.

EAST SHEEN v. GUY'S 1ST XV.

This match was played at Richmond on October 29th. Sheen turned up with a weak team and were three men short, so we gave them the services of Mottram forward. The game from start to finish was of the poorest description, and the narrow margin of a goal and a try to a drop goal, by which the Hospital managed to win, was far from creditable. The play of our back division was lacking all dash, the half-backs being chiefly responsible for this by the slowness with which they passed the ball back to the three-quarter line, and our forwards worked badly together throughout, and seldom formed a good scrum. The tackling all round was bad, very few of the team having learnt that the only sound method of collaring a man is by the waist. Both tries were gained in the first half, one by Wetherell and one by Sime, as also the drop goal of our opponents, no scoring taking place in the second half. Team :—

GUY'S.—G. B. Muriel (back); F. Sime, F. E. Wetherell, A. Dowsett, F. D. E. Jackson (three-quarter backs); R. S. Thorpe, A. Kinsey-Morgan (half-backs); E. G. Goddard, P. D. Hunter, H. E. Rashleigh, H. V. Bagshawe, M. D. Wood, E. Cohen, W. Tyson (forwards).

LENNOX v. GUY'S 1ST XV.

This the first home match of the 1st XV. was played on Saturday, November 2nd. Guy's won the toss and elected to play from the Pavilion end. At the start our forwards came away well, and Dykes making a good dribble to the visitors' twenty-five, looked like scoring but was checked near the line. Play continued for some time in their quarters, but the passing of our back division was too slow to be of any use. The visitors now began to settle down a bit, and the ball was gradually worked to the middle of ground where play was even for

some time till a bout of passing by their back division let in Lindsay Smith; the try, however, was not converted. Wetherell then dropped out but the ball was returned and play again settled in our twenty-five, where Garland was penalised for off-side. The shot at goal being without effect, play for the rest of first half was chiefly in our territory, but nothing further was scored.

On changing ends, our forwards again put in some good work, several times screwing the visitors' pack and breaking away with the ball, but were unable to score a point. By the visitors' full-back relieving the pressure, the ball was again brought to the centre of ground, and in some loose play following a throw in, the visitors' left centre three-quarter got the ball, and with a clever run just managed to fall over the line, a goal resulting. This increase in the score acted as a stimulus to our team, and from now to the finish the Hospital had the best of the exchanges: Garland dribbling the ball as it came out of the scrum in the visitors' twenty-five, evaded their backs, and scored for the Hospital; a good kick by Gwynn, resulted in a goal. Despite the increased efforts of our men, nothing further was added, the game ending in a win for Lennox by a goal and a try to a goal.

Of the backs Wetherell played the best game, his tackling being very effective. None of the three-quarters, however, had much chance of showing up in the offensive, as the halves were so slow in letting them have the ball. Sime on the left wing, when he did get the ball, put in some strong runs.

Both halves were slow. Garland played a good defensive game, but he does not yet know how to pass the ball. The forwards showed marked improvement on Wednesday's form, but do not break up quite quickly enough now. Team:—

GUY'S.—G. B. Muriel (back); F. Sime, F. C. Wetherell, A. C. Ransford and F. D. S. Jackson (three-quarter backs); J. N. Gardiner and J. O. Garland (half-backs); E. G. Goddard, P. A. Dykes, P. D. Hunter, W. P. Gwynn, H. V. Bagshawe, H. G. Rashleigh, F. G. Gibson and M. D. Wood.

GUY'S 3RD XV. v. BROCKLEY 2ND XV.

This match was played at Lee on October 26th, and resulted in a win for Guy's by 5 goals 2 tries (31 points) to nil. Although over-weighted forward, we managed to get the ball away to our outsides, who showed very good combination, completely bewildering their opponents. In the first half we scored a goal and 2 tries, the second try being the result of some very pretty passing. Fagge was unfortunately hurt soon after changing ends, and had to retire; but Cloud coming up from back infused considerable vigour into the forward play, and we scored four times. Tries by Clarke (2), Barrow (2), Pike, Spon, and Hicks. Goals kicked by Cleveland. Team:—

GUY'S.—F. H. Cloud (back); W. T. Clarke, H. J. Spon, H. T. Hicks and H. W. Barrow (three-quarter backs); J. H. Bryant and N. H. Pike (halves); F. J. Steward, C. H. Fagge, A. J. Cleveland, H. H. Bignold, Holden, Manson and E. I. Spriggs (forwards).

Golf.

A return match was played v. St. Bartholomew's Hospital on Friday, October 25th, over the links of the Bromley and Bickley Golf Club, and resulted in a win for Guy's by 14 holes.

GUY'S.	Holes.	BART'S.	Holes.
C. Coventry	0	F. Robertson	3
W. G. Mitchell	0	P. Furnival	1
C. Trouncer	0	L. Evans	3
J. Bevis	7	J. Bailey	0
E. N. Scott	4	A. N. Weir	0
F. G. Thomas	0	G. W. Ellacombe	3
P. R. Lowe	5	H. Lance	0
C. Shepherd	1	J. Blagden	0
G. Duncan	7	Dr. Bowman	0
	24		10

On Saturday, October 26th, a match was played against the Bromley and Bickley Golf Club, and resulted in a win for Guy's by 14 holes.

GUY'S.	Holes.	B. & B. G. C.	Holes.
C. Coventry	3	A. Drysdale	0
J. Bevis	4	H. Morris	0
E. N. Scott	0	J. Simpson	0
P. R. Lowe	0	J. Tattersall	5
F. G. Thomas	9	J. Batchelor	0
C. Shepherd	3	G. Grant	0
	19		5

Births.

BRYDEN.—On October 5th, at Harmer Street, Milton-next-Gravesend, the wife of Richard J. Bryden, M.R.C.S. Eng., L.S.A. Lond., of a daughter.

HOWELL.—On October 28th, at Cleeve House, West Hill, Wandsworth, the wife of Thos. Arthur Ives Howell, of a son.

HUDSON.—On October 6th, at Vine House, Cobham, Surrey, the wife of Arthur B. Hudson, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

Marriage.

ASHWELL—LYON.—On the 25th ultimo, at the Parish Church, Pontefract, by the Rev. J. J. Christie, M.A., Rural Dean, Herbert George Ashwell, M.R.C.S., etc., of Mansfield Road, Nottingham, son of the late Thomas Ashwell, of Nottingham, to Elizabeth Beatrice, eldest daughter of J. G. Lyon, J.P., of Carleton Close, Pontefract.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, Guy's Hospital, S.E.

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The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

NOVEMBER 23, 1895.

A case of Functional Abductor Paralysis of the Larynx.

CLINICAL LECTURE BY DR. TAYLOR.

The case which I want to call your attention to to-day is that of a woman, æt. 43, who was admitted to the Hospital on October 5th, and was discharged on October 11th. She had been in the Hospital twice before for very severe dyspnœa. The attack was preceded on these occasions by pain in the larynx. On the first occasion it is mentioned that the vocal cords were approximated in the middle line, and that they moved but very little apart during inspiration. The second time she was admitted for these symptoms was in November of last year. In this report no mention is made of the paralysis of the vocal cords, but I understand that the attack was exactly similar to the preceding one. On both occasions the patient got quite well in a few hours. Since then she has been in the Hospital to be treated for some uterine displacement. She had no more fits of dyspnœa until October 5th, when she was suddenly attacked at 4.45 p.m.

On admission, she appeared to be very bad, the dyspnœa was very marked and there was loud stridor. On examining the larynx, both cords were approximated to the middle line during inspiration as well as during expiration. Urine was normal, excepting that it contained a few leucocytes.

Then the points observed are that patient had early dyspnœa; some hours afterwards she was breathing with difficulty, and had a stridor which was inspiratory. From this and the short duration of the previous attacks, I gathered what kind of case we had to deal with, as I will explain to you later on.

We next made a laryngoscopical examination, when the vocal cords were seen approximated together in the middle line; on inspiration they almost touched one another, and on expiration they were only separated by an interval of about one-tenth of an inch. You can see from this that the air could not enter as it should.

The reason why the cords are approximated in this way is that the abductor muscles of the cords are paralysed. The cords being thus approximated, and the glottis narrowed, the entrance of air is hindered, and a peculiar noise called *stridor* is produced. This term *stridor* is rather of a limited meaning, and has to be distinguished from the terms *stertor* and *wheezing*. In *stertor* the noise is produced in the throat; it is rough in character and low pitched. In *stridor* the noise is produced in the larynx, trachea or a main bronchus; it is of higher pitch and somewhat more musical in character. In *wheezing* the noise is produced in the bronchial tubes, larger and smaller. It may have a still more musical quality, and is often of higher pitch than stridor; but it is often very difficult to distinguish between stridor and wheezing.

The causes of these conditions are those which produce a narrowing of the air passages. These are:—

A. In the larynx.

1. *Laryngitis.* Catarrhal. Syphilitic. Tubercular. Diphtheritic.

A pronounced stridor is less frequently caused by tubercular disease than by the other conditions.

2. *Cicatricial.*
   This is a somewhat rare cause. It occurs as a result of syphilis, and occasionally as a result of perichondritis, which may follow some septic condition, as in typhoid fever.
3. *Tumours of the larynx.* Papillomata. Malignant tumours.
4. *Foreign bodies.*
   For example, peas in children, which may have got into the larynx without anybody knowing anything about them.
5. *Paralysis of the vocal cords.*
6. *Spasm of the vocal cords.*

B. *In the trachea.*

1. *Foreign bodies.*
   These, however, do not often obstruct the trachea, as they quickly pass on to the bronchi.
2. *Stenosis.*
   This is almost always due to cicatrization of syphilitic ulcers.
3. *Tumours pressing from without.*
   These may be aneurysm, malignant lymphoma or sarcoma.
4. *Enlargement of the thyroid gland.*

C. *In the bronchi.*

The two main bronchi may be narrowed by the same causes as operate in the trachea, viz., *foreign bodies*, *syphilitic cicatrices*, and the presence of *aneurysms* and *tumours*.

These are the chief causes of the narrowing of the air passages.

I cannot now take all these causes and discuss them separately, so that I shall confine myself to the subject related to the case before us.

In diagnosing these cases it is useful for the student—as a mental exercise, at any rate—to think of all the possible causes and exclude them one by one. But in this case, as I said before, we had formed an opinion as to the cause of the trouble, and having the means of diagnosis at hand we used it, that is, we examined with the laryngoscope and the question was settled at once.

The laryngoscope, however, may not determine every case, because the obstruction may be below the larynx, but in such case it helps us towards the diagnosis by excluding this part of the respiratory tract. The instrument is thus of great value, and every one of you should learn how to use it at your earliest opportunity. I do not say that you ought to be able to recognise and distinguish all the most obscure conditions, but I do think that everyone ought to be able to say whether the larynx is healthy or not.

In cases of chronic obstruction of the larynx, it has been too common to put them all down to syphilitic laryngitis; though syphilis be responsible for the obstruction, there are more ways than one in which syphilis may produce it. In fact there are two distinct ways in which syphilis may produce obstruction besides by laryngitis, which I shall mention presently. It would be, therefore, very unscientific, to say the least of it, to put chronic obstruction down to syphilis without first looking with the laryngoscope.

I may here mention one or two cases bearing on the use of the laryngoscope. One evening, some years ago, a man came in with bad dyspnœa and stridor. The house-surgeon arrived with tracheotomy tubes and instruments, in case the dyspnœa should get worse. He remained in the neighbourhood all night. By next morning the man was no worse, and on examining with the laryngoscope, the larynx was found to be perfectly healthy. On further examination, it was found the dyspnœa was due to an aneurysm pressing on the trachea.

In the case of children, it may be very difficult to use the laryngoscope. In such cases, diagnosis may be very difficult; for example, in the case of papillomata, their history not being known. In such cases, the dyspnœa may be put down to subchronic laryngitis or to diphtheria. Papillomata may often be felt, when they cannot be examined with the mirror.

Another class of cases in which a wrong diagnosis is liable to be made, is in abductor paralysis of one vocal cord (generally the left), due to pressure of an aortic aneurysm on the corresponding recurrent laryngeal nerve. This is especially likely to happen when there is not sufficient evidence of the chest trouble to draw the observer's attention to it; and a diagnosis of laryngitis is often made. There is one other way in which laryngeal obstruction occurs in a person with a syphilitic history, viz., from the existence of atheroma of the aorta and consequent aneurysm, which, pressing on the left recurrent laryngeal nerve, causes abductor paralysis of the left vocal cord.

Now to go back to the paralysis of vocal cords and its causal bearing on the case before us.

The muscles of the larynx are divided into two main groups, the abductors and the adductors.

The abductors are the posterior crico-arytenoid muscles.

The adductors are the following:—

Lateral crico-arytenoid muscles, the thyro-arytenoid muscles, and the arytenoideus proprius muscle.

The *abductors* are muscles of respiration, *i.e.*, they open the glottis and widen the passage by moving the cords out during inspiration. If they do not act properly, the air cannot enter so well, and if they are completely or almost completely paralysed, as in this case, the air can only enter with very great difficulty.

The *adductors* are muscles of phonation, so that when they are affected the voice is more or less lost. In these cases the cords may remain apart some distance, or the anterior half of the cords may come together, leaving a triangular space behind, owing probably to the arytenoideus proprius not acting. In either case there is no proper phonation.

In these cases of adductor paralysis respiration is not interfered with at all. Conversely, paralysis of the abductors does not affect speech; and the patient is able to cough. The cords being close together, there is stridor present, and, what is very important to note, this stridor is *inspiratory*, while there is comparative silence during expiration. In obstruction from other causes the stridor is usually both inspiratory and expiratory.

In the cases of abductor paralysis also, the stridor is very variable from time to time. The patient makes a great noise at night, and may be comparatively quiet during the day. In one case which came to me from the country, it was said that people passing along the road at night could hear the noise which the patient made while asleep in his cottage. This stridor is associated with a dyspnœa which is sometimes very serious. Occasionally the cords remain close together, so that the patient dies asphyxiated, unless he is promptly relieved by tracheotomy.

When the paralysis of both adductors and abductors is complete, the cords are in a position half way between complete adduction and abduction. This is called the *cadaveric position*, —*i.e.*, it is the same as the position which the cords assume after death. In this position the cords form a fusiform opening between them. In this case quiet respiration is not obstructed, but the patient cannot phonate properly; being only able to make a hoarse or grunting sound by a forced expiration.

These cases of complete paralysis will arise when there is a complete lesion of nerves. You may produce it on one or both sides, according as one or both nerves are divided, or otherwise suffer a complete lesion. The most familiar instance is the condition of bulbar paralysis, when the paralysis is complete.

This question, why there is this curious liability of the abductors to early failure, has had no adequate answer.

Some suggested that the abductor fibres ran in the outer part of the nerve, and so are more liable to be affected by outside pressure; others, that the abductor fibres had a greater proclivity to disease.

The first is not borne out by any anatomical evidence; the second only re-states the facts.

The next point of interest is this: that although both abductors and adductors are supplied by the same nerve—namely, the recurrent laryngeal nerve—the abductors may be paralysed without the adductors, and the adductors without the abductors. Now, if the recurrent nerves or their nuclei are affected by an organic lesion which is competent to, and ultimately does, paralyse both sets of muscles, it often begins by paralysing the abductors alone; but the adductors are never paralysed by an organic lesion before the abductors.

Whatever may be thought of these attempts at an explanation, one fact is certain, viz., that the abductor muscles may be affected a long time before the adductors, when the paralysis is due to an organic lesion.

Cases in which one sees paralysis of one cord are those of an aneurysm of the aorta; of both cords, those of cancer of the œsophagus. Sometimes one sees it with locomotor ataxy and other central nerve lesions. There are many cases in which no evident lesion can be made out. In these cases, one occasionally gets a definite history of syphilis, and it is thought that it is probably due to some syphilitic lesion of the nerve centres. This is the third way in which syphilis may assist in producing larnygeal obstruction. Thus, there are many instances in which paralysis of the vocal cords means organic disease; but in some cases it is functional. The functional cases generally take the form of adductor paralysis. Rarely, abductor paralysis may also be functional. I may say that adductor paralysis occurring alone is invariably functional. The chief symptom in this case is aphonia, which is variable, the patient being able to phonate a little some days and not at all on others. This form of paralysis is generally cured with promptitude by the application of galvanism.

To go back to the case before us. This patient undoubtedly suffered from the rarer form of abductor paralysis; that is, functional abductor paralysis. The patient had two

precisely similar attacks previously, and had rapidly got better. On this occasion we applied Faradic electricity to the outside of larynx, and the patient was quite well in less than two hours. If we had applied the electricity to the interior of the larynx, the cure might have been instantaneous; but I think it was sufficiently quick as it was. Preceding the paralysis, the patient had a slight attack of local catarrh. I think that the irritation caused by this was probably the exciting cause of the paralysis. Patient went out five days after the treatment.

Though the condition is rare, I have met with three or four similar instances. I referred to some in a paper in the "Guy's Hospital Reports" some years ago on abductor paralysis. One was the case of a nurse to whom I was called; she had been suddenly attacked with stridor and dyspnœa. I examined the larynx and found well-marked abductor paralysis, which passed off by the next morning, so that she was then perfectly well. She had been on night duty, and was no doubt somewhat overworked.

Many of these cases get well quickly; but the condition may persist with variations for weeks. It should be recognised that the organic form may be very serious; and, as I mentioned before, a patient may suddenly die of asphyxia. If the patient has repeated attacks of bad dyspnœa, so that life is threatened, it may be necessary to perform tracheotomy as a precautionary measure, leaving the tube permanently in the trachea.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

MARY
1. Phlebitis.
3. Mitral and tricuspid regurgitation. Bronchitis.
8. Mitral stenosis and regurgitation.
12. Communication between pulmonary artery and aorta.
15, 20. Chlorosis.
17. Ulcerative endocarditis.
28, 40. Aneurysm of thoracic aorta.
35. Mitral.
38. Mitral regurgitation.
50. Mitral stenosis and regurgitation.

PHILIP
6. Dilated heart. Dyspnœa.
9, 10, 35. Aortic disease.
38. Pericarditis.
39. Aneurysm of aorta.

STEPHEN
3. Adherent pericardium.
21. Aortic disease.
34. Mitral regurgitation.
35. Mitral stenosis and regurgitation. Aortic regurgitation.

MIRIAM
20. Mitral stenosis and regurgitation. Tricuspid regurgitation.
26. Thoracic aneurysm. Choroiditis.

Nervous System.

MARY
32, 45. Chorea.
34. Syringomyelia.
46. Hemiplegia.
49. Paralysis agitans.

PHILIP
20. Locomotor ataxy.
26. Hemiplegia.
36. Hemiplegia, anæsthesia, etc. ? Cause.

STEPHEN
6. Paraplegia. Chronic myelitis.
23. Ataxy. ? Cause.
37. Left hemiplegia.

MIRIAM
30. Cerebral tumour. Hemiplegia. Trephining.

JOHN
2. Cerebral tumour. Optic Atrophy.
3. Cerebral syphilis.

Alimentary System.

MARY
4, 11, 19, 23, 26, 42, 43. Gastric ulcer.
27. Jaundice.
39. Appendicitis.

PHILIP
2, 7, 17. Ascites. Cirrhosis of liver.
16. ? Subdiaphragmatic abscess from perforating gastric ulcer.

STEPHEN
1. Gastric ulcer.
10. Ascites. Cirrhosis of liver.
13. Epithelioma of œsophagus.
26. Tuberculous peritonitis.

JOHN
1. Ascites. Thrombosis of femoral veins. Stricture of rectum.
6. Carcinoma of pylorus. Gastro-jejunostomy.

Typhoid Fever.

MARY
5, 9, 21, 37, 41.

PHILIP
25, 37.

Genito-Urinary System.

MARY
6. Tubal nephritis.
13. Granular kidney. Gout.
48. Pelvic peritonitis.

PHILIP
12, 14. Diabetes mellitus.
13. Granular kidney. Hypertrophied heart.
18. Chronic tubal nephritis.
28, 30. Acute tubal nephritis.

STEPHEN
8. Granular kidney. Hypertrophied heart. Gout.

STEPHEN 11, 31, 38. Chronic tubal nephritis.
15. Albuminuria.
36. Chronic tubal nephritis.

Respiratory System.

MARY 24. Pleuritic effusion.
47. Bronchitis.
PHILIP 3. Pleurisy.
23. Bronchitis.
24. Pleuritic effusion.
29. Lymphadenoma. Mediastinal growth.
STEPHEN 14. Bronchitis.
18. Bronchitis and emphysema. Tricuspid regurgitation.
MIRIAM 18. Phthisis. Enlarged spleen.

Phthisis.

MARY 29.
PHILIP 15, 30.
STEPHEN 9, 30.

Miscellaneous.

MARY 10. Osteo-arthritis.
PHILIP 32. Eczema.
STEPHEN 7. Hodgkin's disease.
20. Congenital syphilis. Enlarged spleen.
MIRIAM 17. Purpura hæmorrhagica.

Acute Rheumatism.

MARY 2, 22.
PHILIP 1, 5, 6.
STEPHEN 5.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN 5. Adenoma of submaxillary gland.
CHARITY 10. Fluctuating swelling below angle of jaw.
14. Central myeloid sarcoma of upper end of tibia. Amputation.
19. Abscess in iliac region. ? Appendicitis.

CASES UNDER MR. LUCAS.

LYDIA 13. Recurrent sarcoma mammæ.
16. Subacute periostitis of tibia. Symmetrical. Persistent since operation for talipes equino-varus five years ago. ? cause.
JOB 2. Stricture of urethra.
4. Stricture of urethra. Large perineal abscess.
7. Irreducible inguinal hernia.
16. Hydrocele of tunica vaginalis.
22. Chronic ulcers. Varicose and eczematous.
24. Tuberculous osteitis of humerus.

CASES UNDER MR. GOLDING-BIRD.

LAZARUS 8. Mastoid Abscess.
8. Hæmatoma auris.
11. Stricture of urethra.
12. Varicocele.
13. Syphilitic testicle. Ulceration of tunics.
14. Senile gangrene. Amputation below knee. Recurrence of gangrene in flaps. Transferred to Samaritan ward.
14. Enlarged prostate. Retention.
15. Dupuytren's contraction.
16. Tuberculous disease of cuboid.
17. Irreducible inguinal hernia.
22. Sinus in gluteal region. ? Sacro-iliac disease.
MARTHA 5. Strangulated umbilical hernia.
7. Scirrhus mammæ.
9. Hammer-toe.
20. Injury to hip. ? Rheumatoid arthritis.
Cot. Spinal caries. Iliac abscess.
ACCIDENT 18. Tibialis anticus tendon divided on inner side of foot.
CORNELIUS 8. Bullet-wound in palm of hand.
18. Wound of knee-joint opening pouch above patella.

CASE UNDER MR. LANE.

JOB 12. Senile gangrene.

In the Out-Patients' Department.

CASE UNDER MR. SYMONDS.

CARIES OF SPINE. LARDACEOUS DISEASE.

Patient was a very pale boy of 15. He came up with a sinus in the buttock, which was discharging profusely. He had always been delicate, and had suffered with his back for some years; he had become much worse lately, and was now unable to walk.

On examination, there was found to be marked angular curvature, but no evidence of hip-disease. Liver was enlarged (1½in. below costal margin), and had a firm, sharp edge. Urine contained a large quantity of albumin. Mr. Symonds diagnosed psoas abscess secondary to caries of the spine, opening through the sciatic notch into the buttock, and lardaceous disease. He said that the following principles should be born in mind in the surgical treatment of lardaceous disease.—

1. Never attempt to erase or excise joints.

2. Always amputate when the disease can be removed, *e.g.* in hip or knee disease.

3. In spinal cases where the disease cannot be stopped do not attempt surgical treatment. It is further to be noted that where amputation is possible, the prognosis is good; the improvement is very often rapid, the liver and spleen rapidly regaining their normal size; in favourable cases the albuminuria also clears up, but sometimes it persists.

Two Cases of Tertiary Syphilis.

A man, about 40, came up complaining of an enlarged and ulcerated testicle. There was a history of syphilis twenty years ago. He said that the testicle had been enlarged for over six months, and that it had been tapped four times. The ulcer formed a fortnight ago.

On examination, the left testicle was much enlarged and irregular in shape; in front was a large ulcer, one inch in diameter, with free undermined edge, and base formed by a tough, yellow, deeply-infiltrating slough.

The diagnosis of tertiary syphilis was made from the irregular enlargement of the body of the testis, the large size of the ulcer, the non-infiltrated, undermined edge, and the typical, tough, adherent, "washleather" slough.

Mr. Symonds dwelt on the importance of a *systematic examination* of every case of supposed tertiary syphilis for confirmatory evidence; thus the following parts should be investigated:—

1. The head, sternum, clavicles and tibiæ, for nodes.
2. The skin, especially of the legs, for pigmented scars,
3. The tongue, for chronic glossitis or scars of deep ulcers.
4. The eyes, for irregular pupils, indicating old iritis.
5. The testes, for atrophy or gummatous enlargement.

In this case there was a node on the frontal bone; there were scars on the legs, and the other testis was small, hard and irregular, so that ample confirmatory evidence was forthcoming. On the other hand, the importance of such a systematic examination was well shown by a case which came up a little later, where a doubtful swelling on the forehead was shown to be syphilitic by an enlarged irregular testis, no other signs of the disease being present.

With regard to treatment, Mr. Symonds said that such cases rapidly get well under large doses of Iodide. Castration should not be performed in a healthy person, but may be required where there is marked syphilitic cachexia. The rapidity of cure was illustrated by another case which came up later in the afternoon, in which a double hernia testis, where the ulcerated surface had measured four inches by three inches, was almost healed after fourteen days' treatment.

Patient, 17 years of age, complained of a large sore on the inner side of the right knee. He is the subject of congenital syphilis, and has been attending the Hospital since he was four years old, during the whole of which time he has been scarcely ever free from some lesion. Unless large doses of mercury are given he goes downhill rapidly. On the present occasion he had been away in the country for a few weeks, and had not been taking any medicine, with the result that a gumma had formed on his leg and broken down, giving rise to a clean-cut ulcer with central slough. Besides this, there were gummata in all stages on his right forearm; thus, there were subcutaneous nodules beneath a healthy skin; others where the skin was infiltrated; others again where it had sloughed, forming deep ulcers, and lastly, numerous scars, the result of the cicatrization of old ulcers. Further evidence of the disease was to be found in patient's inability fully to extend his right forearm from enlargement of the olecranon, resulting from old periostitis, and in a well-marked notch in the cutting edge of the right upper central incisor.

Guy's Hospital Missionary Society.

A meeting was held in the Board Room, on Tuesday, November 19th, at 8 p.m., Dr. Lockhart Stephens in the chair. There were present, twelve sisters and lady-pupils, fifteen nurses, three lady-visitors, and sixteen students.

After a hymn, the Hon. Secretary announced that according to the decision of the Committee there would be nine meetings of the Society in the year, three of which, namely, those held in February, June and November, would be public meetings to be addressed by speakers from outside. Eight o'clock had been fixed on as the hour most convenient to the Nursing Staff. The collections made at the meetings would go towards a fund which was to help in the outfit of anyone from Guy's who should go into the mission field.

The Chairman expressed a hope for the growth of missionary interest in the Hospital. Every medical man, however, should be a missionary in his own field of work. For to him is given an exceptional opportunity of offering advice at a time when the mind is most fitted to receive it. But whether at home or in the mission field he has always to guard against the subtle temptation of boasting of cures affected, when he has but used the remedies entrusted to him, and the cure has been effected by a Higher Power.

The first essential for a man intending to become a medical missionary is that he should stand as high in professional merit as possible; and he should try to occupy a residential post, which would give him good experience of bearing responsibility. In the second place, he should, as a student, try to become acquainted with the conditions of his future work by studying the reports of medical missions, and the blue-book reports of naval and military surgeons practising in foreign parts. Finally, he should only go into the field if he felt a definite call to the work.

It is, indeed, a good sign that this Society has been established; for it will not only act in influencing its members, but will re-act upon the whole life of the Hospital, and help to remove the stigma that is still attached to the medical student from the days of Dickens' caricature. It is to be hoped that some past or present Guy's man will soon offer himself for the work to one of the societies that engage in medical missions.

Canon Scarth, Vicar of Bransted, Kent, gave an interesting address, of which we have only space for a brief *résumé*. In the first place, he said, we should interest ourselves, not only in one particular missionary society, but in the whole of Christian missionary work, and so watch the plan of progress of the Christian kingdom. Thus, we may notice in the past that countries

which have been reached by Christianity from the east have now been permeated by its influence to their western limit, while missions from west to east have to a large extent failed. Thus, Christianity has spread westwards from Jerusalem through the whole world, while Arabia is the only country that has not yet been evangelised. We may notice, also, the return of the Jews to Palestine, where, at the beginning of the century, there were but 8,000 Jews, and now there are 140,000, owing to the disinterested efforts of Baron Hirsch and Baron Rothschild. Another most noticeable fact is the great activity of Mahomedan missions. The largest missionary college in the world is a mosque in Cairo, where there are 10,000 students, 2,000 of whom go out annually to the different parts of Africa, of which they are originally natives. Only the head of this college receives any payment, and he is by birth a Jew. Finally, the Canon wished he had time to narrate his experience of twelve years' life as a layman in China, and to vindicate the character of the Chinese, whom he considered as the best of men, and had always found absolutely trustworthy.

Dr. RIGG, M.B., B.S., described his work in a southern district of China. He noticed, first, the difficulty of the languages, of which there was one in about every forty miles. To learn the language of any particular town was a matter of some nine months' hard work, but was possible for anyone with diligence and patience. The men, with whom alone he comes in contact, are very friendly, and even the literate classes are eager to hear of the doctrine that he preaches.

Medical work has a great prestige in China, and that of one qualified man would give scope for the evangelising work of at least six other missionaries. But the Chinaman is hard to influence, for although he has ideas of morality, he has none of unselfishness, and so is for a long time at a loss to understand the missionary's position. As to the medical and educational aspect of the work, both labour under great difficulties. In training assistants, the only books there are to work on are a bad translation of Gray's "Anatomy," and a very primitive rendering of Huxley's "Physiology." The rest must be supplied by notes and dictation. Seven years have thus been spent in training four natives, who still are unable to diagnose phthisis with certainty, but can do much useful work, and have been left in charge of Dr. Rigg's three hospitals. As to treatment, the Chinaman thinks nothing of any deformity, such as hare-lip, so long as it does not prevent his working; and in no case must any patient be treated unless cure can be guaranteed, for if death occurs the other patients will at once leave the hospital rather than remain in company with the spirit of the departed. Antisepsis, too, is often an impossibility, and even if the operation is successful, the result is often marred by the patient at the same time consulting native doctors, or neglecting rules. A man with a fractured thigh, for instance, will get up and walk about the ward; or a man with dysentery will be found eating nuts behind the doctor's back. Nevertheless, great glory is given to the hospital, even when a case is moderately successful. The most common operations are iridectomies, while the chief medical work is in leprosy and skin diseases, malaria, dysentery, chronic phthisis, bronchitis and rheumatism. In conclusion, Dr. Rigg referred to the personal difficulties of the life of a medical missionary, but promised work of never-failing interest to any that would offer the help for which there was so great a call.

After a hymn and the blessing, the proceedings terminated.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Should not Keats have a Memorial at Guy's?

DEAR SIR,—The interest aroused by Dr. Wilks' timely letter in your last issue is my excuse for writing under the above heading. For a long time, indeed, a "little clan" at the Hospital has felt that the present centenary of Keats' birth should receive some recognition from Guy's; but during the past week so many opinions have been expressed to this effect that one no longer hesitates to raise the question. I must premise, however, that I do so personally only as the representative of many who are interested in the matter.

We are in times untoward for the suggestion of a *fresh subscription list, however worthy the object*; but I think the monetary side of this matter will never give trouble. Keats has now so many admirers, and yet, in England, so little in the way of monument, that, were it decided to erect some sort of a memorial tablet at Guy's, help from outside would be forthcoming in plenty. The questions we have to settle are—first, whether there is any consensus of opinion among your readers that such a memorial is desirable; and, second, whether the authorities would permit its erection preferably in some part of the old buildings actually known to the Poet.

If anyone will take the trouble to search the old Registers still to be found at the Dean's office, he will find that John Keats was duly entered as surgeons' pupil at Guy's on the 1st October, 1815, being then just four weeks short of his twentieth year. In common with all others at that date, he obtained by his entry the privileges of the United Borough Hospitals. But some men actually made their entry at Guy's and others at St. Thomas's; it is well to note, therefore, that Keats did the former, and became a properly constituted Guy's man. Against the names of most of his contemporaries in the Register there is recorded the date at which each obtained a final certificate of diligence and proficiency on leaving the Hospital. Opposite the name of John Keats there is no such record. We are the more grateful, therefore, to Dr. Wilks for having obtained proper evidence that the poet became

duly qualified to practise. Keats himself, indeed, had full confidence in his capabilities as an apothecary if not as a surgeon. He writes as late as 1819:—"I have enough knowledge of my gallipots to ensure me an employment and maintenance."

The surgeons of those days did not seem to have any monopoly in their own pupils, and though Keats was attached to Mr. Lucas, he probably came far more under the influence of the powerful personality of Sir Astley Cooper. We know, indeed, that the great surgeon took a special interest in the "cheerful crotchety rhymester," personally choosing for him a lodging and a companion (*vide* Dr. Wilks' article on Keats in the Biographical History of Guy's Hospital). Indeed, I often fancy that Sir Astley, whose profound influence over the students was proverbial, may have stood for Apollonius in "Lamia." "Apollonius sage, my trusty guide, And good instructor." The surgeon was but 47 when Keats was at Guy's, but this probably seemed a sufficiently advanced age to the youthful poet. Keats must have spent many hours with his muse during his medical course, and probably did not get entire sympathy in the matter from Cooper or his other teachers.

"Do not all charms fly
At the mere touch of cold philosophy?"

But, on the other hand, far too much has been made of the Poet's distaste for science, and unfitness for the medical profession. The latter, it seems to me, he never admitted himself. We see, indeed, from the letter quoted by Dr. Wilks, that he felt unfit to operate, but as late as February, 1819, he writes to his brother and sister that he has serious thoughts of going to Edinboro' to study for a physician. He does not pretend to any enthusiasm, but his chief objection is peculiar—"I am sure I could not take the fees!"

As to his distaste for science, read the following from a letter to John Hamilton Reynolds, dated two years after he took his diploma from the Apothecaries:—"Every department of knowledge we see excellent, and calculated towards a great whole. I am so convinced of this that I am glad at not having given away my medical books, which I shall again look over, to keep alive the little I know thitherwards!" The narrow utilitarianism which was, perhaps, more prominent in those days, naturally drew from such a mind the protest against a purely destructive science, which is found in the fine lines from "Lamia," beginning "There was an awful rainbow once in heaven." But after all, the essence of the Poet's Belief—

"Beauty is truth, truth beauty,—that is all
Ye know on earth, and all ye need to know,"—

might as properly be written up in a laboratory as in the chamber of a poet or artist.

But the point, sir, is that Guy's once nourished a son whose name, since his death, has gathered honours as great as any that have fallen to the share of her (so to speak) more legitimate offspring. To many of the latter she has raised memorials—should she not spare one to her poet son (a changeling if you will), but one who also drank at her breast?

Many believe that a day will come when such a monument will do high honour to the place whereon it stands.

In conclusion, it should be pointed out that the year Keats spent in the Borough was one of immense importance in his life. His genius was then gathering strength for its spring. Immediately after he left, the period of active literary production began, and ceased only with his early death.—I am, etc.,

F. G. HOPKINS.

Guy's Hospital Auxiliaries' Mess.

THE above Dinner, which was started last year, was held for the second time on Wednesday last, at the Guildhall Tavern, Surgeon-Major R. Clement Lucas, F.R.C.S., being in the chair. A very enjoyable evening was passed, the dinner being followed by some excellent speeches and a smoking concert, and it was very gratifying to note that the number present was considerably in advance of that attending the first dinner, though at the same time there was a fairly large proportion of black coats mixed with the various uniforms, a state of things which one would hope to see remedied in the future—not by the absence of those who wore "mufti," but by their exchanging, for the nonce, those sombre garments for some of "the widow's clothes." The Staff of the Hospital was represented by Dr. Pitt, Dr. Bryant, and Mr. Hopkins, in addition to the Chairman, and Dr. Pitt's presence was especially appreciated, from the fact that this year he has presented to the Hospital a cup, to be won each year by the best individual rifle shot, hoping by so doing to improve the general shooting of the members of the Rifle Association, and to give the Hospital a better chance of once more holding the Inter-Hospital Shooting Cup.

The Chairman and Dr. Pitt both made excellent speeches, which showed their goodwill and sympathy to both members of the Auxiliary Forces and to men at the Hospital, especially when the two are combined; it may, *en passant*, be news to some who read this, that after having resigned his commission owing to his severe illness some time ago, Mr. Lucas was subsequently offered the Honorary Colonelcy of his old corps, which post, however, he thought it in the interests of the corps for him to decline, remarking, not inaptly, that they had better offer it to a peer or a millionaire.

A lengthy and excellent musical programme had been arranged by Messrs. Veall and Harrison—to whom great credit is due. Amongst the items to which especial praise must be given is the recitations of Mr. Frank Goldsmith, whose rendering, particularly of "Kissing Cup's Race," was superb, and to the song of Mr. Tom Godfrey, whom everyone was pleased to hear again. A very pleasant and friendly evening finally came to a close with "Auld Lang Syne" and "God save the Queen" shortly after 11 p.m.

Guy's Hospital Debating Society.

THE Society met on Saturday, November 16th, at 7.30 p.m., in the Club Smoking-room, Mr. F. G. Hopkins in the chair. There were some forty members present.

Mr. M. HAMBLIN SMITH moved—"That the present system of medical education is urgently in need of reform." The mover admitted at the outset that in attacking any old system there was always the advantage that many holes could be picked in it, however comparatively perfect the system might be; but that in doing so there was always Tory feeling to be encountered, and in this particular case a certain amount of vested interest. The present system of medical education is controlled by the British Medical Council, a body which has considerably more power than the Incorporated Law Society in the solicitors' profession, or the bishops in the education of their clergy. This power, however, is used far too little, and we may best criticise it by tracing the life-history of the ordinary medical student. In the first place, the entrance examination is a bar to no one; whereas it would be far kinder to tell a man at once, if destitute of brains, that he was not wanted. Of the preliminary scientific studies, those of botany and animal morphology are useless for our purposes, and those of chemistry and physics are not treated fully enough. As to physiology, some may consider the subject useless, others consider it as all-important. Human anatomy is often not taught surgically, and is made to pursue a man to the last to an unnecessary degree. Pathology is a loathsome subject, and if perhaps it is necessary, it is not taught sufficiently. The clinical teaching is arranged so that a clerk sets to work on cases without any previous teaching. Lectures are a remnant of hoary antiquity, once useful in the days when books were scarce, but now involving a sheer waste of time; the system of being signed up for lectures being valueless. The proof of our obstetric work being useless is that mishaps practically never happen, despite the ignorance of our new externs; and there is no practical instruction in gynæcology. In everything, in fact, the order is haphazard, and, as one wit had remarked—he was unaware, until he saw the announcement of the debate, that there was any present system of medical education. Then, the examinations are wrong in many ways. The subjects of the final examination should be taken only *en masse;* a choice of questions should be allowed; the clinical examination is futile, that adopted in Japan being far better—at least for the candidate—which insists on a candidate becoming resident surgeon or physician for a short period, and judges on the results. Finally, when a man is qualified he often finds that he loses considerably from not having the supposed distinction of a university degree, when he may be the superior of many M.B.'s and B.S.'s. There is, therefore, urgent need for reform; and the institution of post-graduate classes is a hopeful sign. The value of the evening's decision would be considerable, for Guy's are in the front of all reforming movements, and our fame has so far spread through England that a letter has recently been received from Bristol asking for details of our debating society, which, as one of the leading medical debating societies of London, it was hoped to copy in that town.

[If we may venture to criticise Mr. Hamblin Smith's speech, it would be to say that it suffered rather from being a bundle of grumbles—no particular stress being laid on any underlying principle which could be attacked, and no definite suggestion of reform being proposed. In expression and delivery, the speech was as refreshing as is his wont.]

Mr. E. A. PETERS, in opposing the motion, argued that medical science is continually progressing, and that as the schools cluster round the centres of scientific advance, our systems of education, which are after all but a secondary consideration, are bound to progress correspondingly. This is shown by the addition of surgical degrees to the degree-list of our ancient universities. More radical subversions of system are dangerous, as may be learnt from the history of medical arrangements in almost any military campaign, towards the end of which the system in use breaks down, and has to be superseded by a new system, which in its turn is shown to be totally wrong in the next war. Of the mover's many objects of complaint one of the most important was the entrance examination; but it would be a great mistake to cut a man off the profession because he happened to have failed in classics. Clinical work is of a different order, and is the one thing of paramount importance in our training which remains unaffected by any system of technical education. Finally, as proof of the continual and natural advance of such systems, notice may be taken of the growing custom of lectures and instruction on special subjects being given by their particular exponents, and of the large sum of money about to be spent on a physiological laboratory.

Mr. Peters, despite numerous illustrations from military medicine, was noticeably unwarlike in dealing with the opener's arguments. Perhaps a little more "verve" would have added to the effect of a speech which was decidedly thoughtful and interesting.

Mr. S. COPLEY considered that the opener had suggested no alternative system and had grumbled far too much; but he failed to agree with the opposer, that a successful system of education could be judged from the opinions held by patients of their medical advisers. The best men often win but feeble opinions from their patients.

Mr. R. HOWARD, in a somewhat didactic tone, explained the present system of education as consisting of two parts—pure and applied science. The pure science was necessary for the understanding of the applied, and the examiners should be professors rather than practitioners. Lectures are useful as introductory to the reading of text-books. The great advantage of the whole of the present system, especially in Guy's, is the large amount of responsibility given to the student.

Mr. W. C. C. PAKES announced to the astonished House his total conversion to the views of the mover; nay, he even held that the present system was rotten to the core. He quoted instances of the terrible illiteracy of many "stewdents," as one man spelt his employment; and expressed a pious wish for further cultivation of physiological knowledge and of the logical faculty, and his total disbelief in text-books or lectures, with the exception of the ideal clinical lecture.

Mr. F. E. FREMANTLE expressed mild surprise that Mr. Pakes had so easily undergone conversion; and suggested that a gentleman of such calibre could hardly continue to associate himself with a system that he considered rotten to the core. It was well enough, too, for Mr. Pakes to spurn text-books and lectures on streptococcus pyogenes, but were it not for the present system of education, streptococcus would have remained a thing unknown to many men who have now been forced to learn of it.

Mr. J. M. FORTESCUE-BRICKDALE suggested that men should have some experience of the post-mortem room before entering the wards; and remarked that clinical study, far from being a science, rather proved the utter uselessness of science.

Mr. J. A. REASIDE objected to the unfair distinction between different medical degrees, and advocated a single public examination for the title of M.D. He proceeded, with preliminary apologies for suggesting so Utopian an idea, to propound a scheme whereby the profession should be reconstructed on the lines of the old religious orders, with the same life-vows of poverty, obedience and chastity. Their members would adopt the principles of true socialism and community of goods; and whereas many with bare-faced iniquity now openly profess that they do not keep abreast of the times, they would under such a scheme be compelled to keep up to date.

Mr. F. H. HARDY marvelled at Mr. Fremantle's description of streptococcus as a bacillus; and expressed it as his opinion that "lectures are rot."

Mr. E. I. SPRIGGS considered that we lose the value of lectures from not attending to them or taking notes; and that writing and spelling are no criterion of a man's abilities, for many who cannot pass the London Matriculation become excellent physicians and surgeons, the converse being equally true. In support of the study of human anatomy he contended that a really good anatomist could pick up anything to which he really turned his mind.

The CHAIRMAN here remarked that it might be of interest to members to know that the question of a compulsory three months' clinical instruction before entering the wards was now under consideration by the authorities.

Mr. L. C. A. SAVATARD, in a most welcome and creditable maiden speech, corroborated former speakers in advocating the better use of lectures, having noticed that men who took notes assiduously always did best in the examination room. He expressed doubts as to the feasability of Mr. Reaside's scheme until the arrival of the millennium; and considered that the same speaker's grievance as to many good practitioners being unable to style themselves doctors, was due absolutely to their own fault.

Mr. S. H. CROUCHER, on the other hand, said that many men could not decide on the value of the different qualifications until too late to take a university degree.

Mr. B. F. RICHMOND held that individual effort and character had been left too much out of consideration; and that as they are the central factors in a good education, ward work should not be deferred for three months, as was proposed.

Mr. PETERS and Mr. HAMBLIN SMITH, in their replies, showed that they were both contending for moderate reform; the latter remarking that although proposing to destroy the edifice, he would, nevertheless, use the same bricks and mortar in its reconstruction. In replying to Mr. Spriggs, he explained the zeal of Scotchmen and Germans in taking notes at lectures—a practice which he himself found hopeless—as due to the fact that they are allowed to do so little actual clinical work.

On a show of hands, 11 votes were recorded for and 17 against the motion, which was therefore rejected by a majority of 6.

A vote of thanks was passed to the Chairman, and the House adjourned.

On the whole, the Society may be congratulated on a most successful debate; the speeches were at least up to the ordinary level, and interest in the subject was fairly well maintained to the end. It is to be hoped that men may learn to value more the opportunity which the Society affords of practice in public speaking, an acquirement which may prove of incalculable use to them in future life.

From the Gazette's Special Pathologist.

NOTICES.

H. A. C., SAXMUNDHAM. There are no cancer cells or fragments of growth in this material. It chiefly consists of mucus streaked with blood, and altered epithelium, shed from the mucous membrane. It is such as might result from mucous colitis or subacute enteritis.

J. E. Z. H., WARMINSTER. After 24 hours' incubation on blood serum, the resulting growth consisted of Klebs-Löffler bacilli, with a large admixture of staphylococci.

W. R., MAIDEN NEWTON. No tubercle bacilli could be found in the sputum.

C. D. M., BOURNEMOUTH (I). After 24 hours' incubation on blood serum, the resulting growth was found to consist entirely of cocci arranged as streptococci. No Klebs-Löffler bacilli were present.

C. D. M., BOURNEMOUTH (II). After 24 hours' incubation on blood serum, the resulting scanty growth was found to consist of cocci arranged in pairs. No Klebs-Löffler bacilli could be detected.

PATHOLOGIST.

Passim.

We have great satisfaction in announcing that His Royal Highness the Prince of Wales has promised to take the Chair at the first Festival Dinner ever held in aid of the Funds of Guy's Hospital. This Dinner will take place in May next; the exact date and other particulars will be announced in due course.

It has been thought advisable to defer publishing further any particulars regarding the progress of the Sustentation Fund till our next issue, which, we may mention, will probably contain the first list of donations and subscriptions. Any contributions, therefore, which are on the way should reach the Treasurer in about ten days' time, if the donors would like their name to appears in such list. The old Guy's Committee continues to grow, but as there appear to be many names yet to come, we also hold its publication over.

It appears, after the grand number of our supporters who witnessed the victory of the Association Team in the first round of the Surrey Cup, viz., TWO, that no apology is needed for reminding our readers that the second round (v. Reigate Priory), takes place to-day week at Reigate. Everyone remembers our old opponents as our conquerors in the Final two years ago at Guildford. We trust the Team will not spoil their very excellent chances of success—as shown by their recent form at Eastbourne—by failing to go in for even a moderate course of training—as yet we see no signs of it; otherwise they may have themselves alone to thank for defeat.

Our continued success in the higher examinations almost smacks of monotony. However, the Gazette has again to congratulate a host of six successful out of eight candidates for the First F.R.C.S. In the Final M.B. Lond., we have done even better, with thirteen passes out of fourteen, amongst which Messrs. Every-Clayton, Handley, Salter and Thomas have been placed in the first-class. Now we hold our breath with suspense in awaiting the result of the Honours Examination; we know it will not disgrace our past record.

The Library has lately received a present of several volumes of works of fiction from Mudie's Library.

Without casting any stigma on the prowess of the senior men who have taken up the Debating Society, we can safely assert that this well-conducted organisation has failed—and that miserably—in one of its chief objects, which was to act as an oratorical school for junior men; and this is especial food for commiseration, as the secretaries and committees, both past and present, have made every effort—both in the subjects of the debates and in other ways—to make the society a suitable bait to their younger brothers. On last Saturday evening one junior man spoke, a few others were present, but the majority of the audience were quite senior. The cure for this obviously rests only with the junior men themselves.

Everyone will congratulate the Rugby XV. on their recent slight return to form and luck, as shown by their draw with Croydon; the arrangement of an extra fixture with the latter was a mutual act of common sense after our late differences, which, to judge by the keenness and lack of rough play last Wednesday, seems to have mingled good with evil results.

As will be seen in another column, this was K. B. Alexander's first appearance since his soda-water-bottle escapade—we trust the moral is not to take it neat—and we can hope that his individual play and presence will act in an enspiriting manner on the team in general.

To-night, at eight o'clock, the Physical Society will hold its first pathological meeting in the Hospital Library.

London University men who are not members of the Guy's Hospital London University Club, are reminded that the committee meeting for the election of new members is fixed for next Monday. The objects of the club, its list of members and officers have been widely made known by printed circulars, which have been sent to every London undergraduate now about the Hospital. Any student—past or present—eligible for election, who has not received one of the circulars, should communicate at once with one of the Secretaries, Dr. J. H. Bryant and Mr. C. H. Fagge.

The Dental Society.

A MEETING of the Society was held on Tuesday, November 12th, Mr. Badcock, Vice-President, in the chair.

The minutes of the previous meeting having been read and confirmed,

The following casual communications were brought forward:—

Mr. F. H. CARPENTER.—A model showing Persistence of Temporary Canine and Misplaced Canine.

Mr. GOADBY called attention to the modulus of elasticity for dentine, determined from Dr. Black's results and its near relation to that of apatite the molecular arrangement of apatite and dentine generally being considered approximately the same.

Mr. PRATT.—An interesting case of Necrosis. Patient, a female, æt. 36, had an abscess formed at root of a devitalised lower lateral about Christmas, 1894. She had the tooth extracted, but afterwards noticed a constant discharge from the socket; this lasting a very long time, she came up to the Hospital in October, 1895, and saw Mr. Maggs, who extracted the right lower central and lateral, as the abscess now extended to the sockets of these teeth. There was a thick discharge from the sockets. On examining the apex of the lateral, "needle-point absorption" was found. Patient throughout had a throbbing pain extending from canine to canine, and noticed in the discharge small pieces of "rotten bone."

Mr. ROUW said he thought the case similar to "perforating disease of the palate," and suggested that it might be the result of syphilis.

Mr. G. A. PEDLEY agreed with Mr. Rouw. He had had a case like this one under his treatment in Burmah.

Mr. PLUMLEY.—A case of alveolar abscess.

Mr. HOUNSELL.—A model showing abnormal size of mouth.

Mr. BASCOMBE.—Models showing canine erupted between first and second upper bicuspids; also persistence of temporary molar.

Mr. SNELL.—Models showing a difficult regulation case.

The CHAIRMAN then called on Mr. E. E. HEESOM for his paper on

"CLEFT PALATE."

Mr. CHAIRMAN AND GENTLEMEN,—The malformation which it is the object of this paper to describe is one of the hardest to bear of the minor ills that flesh is heir to. In every direction the unfortunate owner of cleft palate is handicapped. Socially his misfortune too often causes him to be ridiculed, or even worse, to be pitied. Possessing possibly histrionic, musical or business talents he is doomed to find the otherwise easily-opened doors of success closed or rusty-hinged to him through the unfortunate fate which it is beyond his manhood to master. Speech with his nearest and dearest friends, the free gift of the lowliest, is painful; with strangers all but impossible. His *D* approximates in sound to *N*; his *B* to *M*; *K*, *G*, *S*, *T*, *Ch*, are generally impossible sounds to him. Deglutition, too, is especially in infancy a difficult and even dangerous process, the food tending to be forced through the cleft into the nasal fossæ, or being ill-directed to pass into the trachea. And though gradually the muscles of the remaining parts acquire the habit of retaining food in the natural cavity, yet the patient never has the freedom that a normal soft palate would give him. But as the fate to be mastered is great, so the ingenuity displayed in conquering it has been great and its directions varied, and for the proper understanding of these it is necessary to give some preliminary description of the malformation to be remedied.

The subject divides itself very naturally into two great classes: 1, Congenital; and 2, Acquired. Congenital cleft of the palate is due very generally to arrest of development, not, as is sometimes stated, to mere arrest of union, since there is, in the majority of cases, absolute deficiency of the tissues. This arrest of development, moreover, may be definitely said to take place before or about the tenth week of intra-uterine life, as the normal fœtus union is complete at this time. It may not be inappropriate to give a brief description of the development of the parts affected in cleft palate. What may be called the oro-nasal area is formed from three principal processes, which grow, as it were, from the angles of a triangle. From the basal angles, the first visceral folds grow forwards and inwards from the rudimentary alæ of the sphenoid bone, to form the lower jaw, and are called the inferior maxillary processes. The third or apical process of the supposed triangle is the fronto-nasal, growing down to bisect a new base formed by the ingrowing of two additional secondary processes jutting from the middle of the sides of the triangle, and joining in the median line. These are the superior maxillary processes, and from the junction of these the palatal process and *velum palati* are ultimately formed. There is thus left between this and the joined inferior maxillary processes a lozenge-shaped opening—the rudiment of the future mouth, formed by these primary and secondary processes and of which the fronto-nasal process completes the periphery. The fronto-nasal process is at first a short broad projection consisting of a median and two lateral processes—the external nasal processes. From the deep part of the central portion is eventually formed the nasal septum, while the superficial portion appears in front in the form of a broad process prolonged on both sides as the internal nasal process, or incisor buds of Coste. From these the intermaxillary bones are developed, and it is from the lack of union of these that the very rare cases of central hare-lip and incisor cleft of palate are formed. They have not usually any connection with palatal lesion, which, if it exist, is rather a co-incidence than a sequence. From the foregoing facts it is evident, that if the superior maxillary processes do not develope or unite, or only partially so, greater or lesser cleft will be the result; and

if the superior maxillary processes do not join the intermaxillary bones or only do so on one side, there will be bilateral or unilateral fissure and probably hare-lip. Again the vomer or splenoid bone may grow too rapidly in comparison to adjacent parts, preventing the union of the halves of the palate, and pushing the intermaxillary bones so far in advance of the superior maxillary bones as to render them incapable of forming the key of the alveolar arch. Lastly there may be a total lack of intermaxillary bones.

The junction between the two sides of the fœtus takes place in the oral region from before backwards, and consequently the later the arresting causes have been, the further back will the cleft commence; and thus, while it is common to find a fissure of the hard and soft palates, complicated with hare-lip, it is exceedingly rare to find this deformity in combination with fissure of the soft palate only, and would then probably point to a temporary cessation of the arresting cause or to two distinct causes. From these facts it will be seen that the cleft must always follow the median line of the hard and soft palate, but as the intermaxillary bone is a development of the independent fronto-nasal process. the fissure, if extending farther forwards than its suture, passes towards and through the alveolar process, along the intermaxillary fissure of one or both sides. Such a fissure usually runs between the lateral and canine, or across the site of the lateral tooth germ, generally either dividing this into two ill-formed teeth, or obliterating it altogether. Alveolar fissure is very generally complicated with hare-lip, and is always in the same line—that is, between the position of the laterals and canines, at the alveolar end of the intermaxillary suture or fissure.* The causes which operate to interfere with development are unknown, but anything which puts tension on the nutrient forces, as illness of the pregnant mother, great cold, etc., or affects the nervous centres or supply, as excessive fright, may with certainty be described as a predisposing cause. It has been described by some as endemic to certain localities. Civilisation has been credited with a share in the creation of cleft palates, it being said that the food as now prepared has a tendency to produce the deformity. The principal evidence adduced is that in the Zoo, where the diet of the lions may be supposed to be unnatural, 99 per cent. of the lion cubs have cleft palates. It is also much less common among the poor than rich, and totally absent in savage and semi-civilized races.

Heredity is by some considered a cause, but there is little evidence in support of this view. Like causes acting under like conditions on similar organisms, in successive generations, are known to produce like results, and this fact is the probable explanation of so-called hereditary cleft.

The second great class—viz., acquired cleft palate—is not, strictly speaking, deserving of the name; but as its treatment is on the same general lines as that of congenital cleft, it may with propriety be included in this paper. It is usually the result of accident, such as gunshot wounds, notably suicidal attempts with a pistol, or operation for the removal of growths, etc. It may be the result of certain forms of poisoning, *e.g.*, phosphorus, etc., or may be a manifestation of the tertiary form of syphilis which attacks the palate in common with other flat bones, or may, again, be the result of the breaking down of a syphilitic gumma. The difference between the acquired and congenital cleft is that in the former the lesion is not necessarily in the median line; that the hard palate is frequently perforated without any affection of the soft palate, while in congenital cases a cleft generally extends from behind more or less forwards, but is complete behind; that the speech immediately becomes normal on covering the perforation; that there are in cases of poisoning or of syphilitic origin (and hereditary cases do not differ in this respect from acquired) some constitutional symptoms.

The treatment of acquired cleft palate is necessarily mechanical, since it consists of replacing tissue absolutely absorbed.

In speaking of the treatment of congenital cleft, we will, if you please, first consider the effort which the organism makes to remedy its own defect. Oakley Coles pointed out that in a large number of congenital cases Nature attempts to supply the place of the missing tissue with what appears at first sight to be nasal polypi, but which are, in reality, adenoid growths. He has found them in over one hundred and seventy cases which he has examined. They may be attached to the anterior portion of the nares, or to the back of the pharynx, or between the turbinate bones. In one child, aged seven years, they were well defined, in looking casually into the mouth; in another girl, aged seventeen, they were so large as to completely block up the cleft, and render the patient's speech quite unintelligible. Oakley Coles disclaims the responsibility of saying that these growths are present in even the majority of cases, but thinks their frequent occurrence significant. He regards them as identical with Mayers' "adenoid vegetation."

In congenital cleft, there may be choice between surgical and mechanical treatment. The surgical treatment consists in the operation of staphylorraphy, with or without uranoplasty, the essential features of which are the paring of the edges of the cleft, the division of the tensor and levator palati muscles to obviate tension on the approximated edges, and then suture of the pared edges. When the cleft traversed the bony part, Sir William Ferguson, probably the most successful exponent of this class of operation, drilled small holes in the palatal process near the borders of the bony cleft, and then, having passed catgut joining these holes with those of opposite side, he divided the bone along the line of the holes drawing the two fragments to the median line by tightening the sutures. Langenbech dissected off flaps of mucus membrane including periosteum from each side of the cleft, and united them by suture, the soft parts

* For some unknown reason hare-lip and alveolar fissure are much more frequent on the left than on the right side.

being operated on in the usual way. Bone was, however, frequently not formed.

At the present day, however, it is the general opinion of authorities on this subject that operation is, from the point of view of the patient, always a failure. It is undoubtedly often a surgical success, but except in those very rare cases which are caused more by lack of union than lack of development, and where the tissues are thick and the separation but narrow, surgical interference is likely to stretch the parts unduly, and the cicatrix hardens and leaves a tense, rigid substitute for the velum palati, which cannot be made to approximate to the pharyngeal wall, this being the *sine qua non* of speech, and therefore of true success. Should it, however, be considered advisable to operate, this must not be done until after three years of age, for various reasons, chief among which is the fact that the bony cleft diminishes until this period. Operations for hare-lip, on the other hand, are performed very early in life —between the third and fifth month.

The mechanical treatment of cleft palate and its complications is *the* direction in which we, as Dental Surgeons, find the greatest scope for ingenuity.

The first step is to get an accurate impression of the deformity. No special trays are needed; a selection being made of one which covers the teeth without difficulty. When this is in position, observe the fissured palate and uvula hanging down and add a piece of sheet gutta-percha to the back of the tray, covering the fissure, but not touching it, even in its most relaxed condition. Plaster of Paris should now be mixed to such a consistency that it will not run too freely, some precaution being taken to make it set quickly, preferably by the addition of a small quantity of rouge previously dissolved in the water, as this will be of use in subsequent separation of the cast and impression. Sufficient of this plaster is now to be placed on the prepared tray to fill the roof of the mouth and extending over the apron at the back, to the thickness of, perhaps, one-eighth of an inch. No attention need be paid to the front surfaces of the teeth, as sufficient plaster will probably squeeze out to cover them. The impression having been taken and cast, the next step is to see that it is correct, This is best accomplished by a trial case of gutta-percha prolonged behind between the edges of the fissure, and level with these in their relaxed condition, fitting into the fissure and extending to the termination of the uvula. This being adapted to the mouth and then placed on the plastic cast, the discrepancies will readily appear, and the cast must be made to conform to the corrected shape of the fissure by additions, or the reverse. The former are best made by painting the depressed parts of the cast with thin plaster applied with a brush. If the floor of the nares is required, the process becomes more complicated, but by no means difficult. The first step is to take an impression as just described, and withdraw it as before. Next fill the nasal cavity to the edges of the cleft with plaster, with the last inserted part of which a little cotton has been incorporated. While this mass is still quite soft, re-insert the first impression after having soaped or oiled the part which will oppose the nasal impression. When the latter is hard enough, withdraw the palatal impression, and the nasal cast can be pushed backwards towards the broad part of the fissure, or behind the uvula, and so withdrawn from the mouth. It is possible that there may be difficulty in taking the impression, owing to the inability of the patient to bear anything in contact with his soft palate. This may be overcome by giving patient as a mouth wash a solution of cocaine 1gr. ad $1\frac{\text{z}}{}$, or a tabloid containing half a grain of cocaine made up with borax may be given, or the same effect may be gained by painting the parts with bromide of ammonium. Having at length obtained a perfect impression, it next becomes necessary to decide on the type of apparatus to be used, and this will of course depend on whether the cleft extends through the hard and soft palate, or whether the case is simply one of perforated hard-palate. The apparatus for the first class is known as an artificial velum, and for the second class as an obturator, but there must necessarily be combinations of these in every degree to meet each case.

The earliest obturator was a piece of sponge or lint thrust into the opening of the palate, and this usually caused the opening, however small it originally was, to extend till the whole of the palate was absorbed. But in 1751, Alexander Paré constructed a plate which was attached to a sponge thrust through the opening and held in place by the swelling of the sponge inside the nares. Paré soon, however, improved on this with a plate which resembled a large shirt-stud in form, the lesser plate or head of the stud being elliptical in shape and its longest diameter being equal to the longest diameter of the lesion in the palate. This was passed through the opening into the nares and turned by the connecting screw so that the long diameter was transverse to that of the opening, and it thus, as the stem of the stud was equal in length to the thickness of the missing tissue, held the lower larger plate close to the roof of the mouth. The objection to these plates is, however, that they prevent closure of the aperture by natural means, which in cases of syphilitic origin sometimes happens on successful constitutional treatment when the lesion is only bridged over. The next important step in obturator making was taken in 1820 by Bourdet and Delabarre, who recognised the above-stated principle, and made bands of metal cross the cleft from side to side, supported by the teeth and supporting a plate covering the opening in the palate. Obturators progressed slowly till M. Preterre, of Paris, carried on the work; but to the English, and later to the Americans, belongs the honour of having carried this branch of our science to its present high state of perfection. In 1828, Mr. Snell adopted Bourdet's principle, and had the satisfaction of seeing two cases entirely close by granulation. He constructed an apparatus of great ingenuity, which was the first really scientific means of treating cleft palates. Dr. Hullihen's obturator attempted to restore the function without

restoring the parts missing, by means of two semi-spherical hollow gold blocks fitting into the openings of the posterior nares. These were made adjustable to movement by means of a spiral spring, and their position regulated by a sliding bar on the lingual aspect of the supporting dental plate. This case is, however, at the present day considered more curious than useful, and is here mentioned only to enforce the point that the functions cannot be restored by new means, and that the nearer we simulate nature the more perfect our apparatus will be.

In 1867 the Suersen obturator was first brought forward, and it remains the best of the obturators to this day. It depends upon a recognition of the fact that the superior constrictor of the pharynx has the function of producing or assisting very materially in producing the sounds of speech. It consists essentially of two parts, a plate and an apophysis. The plate merely covers the hard palate and any fissure existing in it. The apophysis commences at the end of the hard palate and is such that its lower surface fits the fissure and is level with the adjacent remains of soft palate, when the latter is slightly raised. When it is at rest, the flaps of the velum palate lie below the lowest surface of the apophysis. This latter consists of a block of rubber attached to the back of the dental plate, and is of such thickness as to remain in contact with the two edges of the fissured velum even when raised to their highest extent. In other words, the thickness of the apophysis is the same as the difference between the height of the soft palate in its raised and lowered condition, and the edges of the velum are thus always in contact with it, in whatever position they may be. To accomplish this and allow for the increased width of the cleft when the parts are raised, the edges of the block are bevelled from below, upwards and outwards. The mode of taking an impression for this apophysis is to fashion a bulb of gutta-percha, approximating in shape to the final bulb, and then to soften it and insert it in the cleft, supporting it well from the front. If the patient is now caused to swallow continually until the mass is cold and the operation repeated until no further change takes place in the shape, the apophysis is complete. Dr. Kingsley, who is one of the best known authorities on this branch of science, has improved on the Suersen obturator in several ways. If he uses vulcanite in its construction, he always vulcanises a hollow block or apophysis, and as the method of doing this is not particularly well known, I may be forgiven for briefly describing it. After the case has been flasked in the usual manner, he makes a paper pattern in sections of the impression of the bulb in the flask and cuts rubber accordingly. This he joins by its edges, care being taken that the resulting little rubber bag will drop readily into the chamber in which it is to be vulcanised. A few drops of water are now to be introduced into its interior, and the edges hermetically sealed by rubbing with chloroform. The apophysis must not, of course, be submitted to the squeezing which the palatal part undergoes, and when the whole is vulcanised it will be found that the steam generated within the bulb has forced rubber into all the depressions of the cast, and that it is so light that it will float on water. Another thing Kingsley recommends in making this form of obturator is, that the bulb should first be made adjustable with a sliding bar, and when its exact position is thus discovered, that the whole apparatus be duplicated in gold, which, he says, gives greater and more natural resonance to the voice. Kingsley gives it as his opinion that this is the best form of obturator, but says further that only after learning to speak with a soft velum will perfect articulation be possible with it.

We now come to the second form of cleft palate apparatus, viz., that which attempts to supply by various mechanical means actual movements similar to those of the natural organs. Delabarre, who added greatly to the knowledge of obturators, was also the pioneer of vela, but here again, Snell, of London, improved on the idea of the former, and made an instrument which appears from the meagre descriptions extant, to have been something between the vela of Sercombe and Kingsley to be presently described. Dr. Stearn, a medical man whose misfortune it was to have a cleft of the soft palate, devised in 1841, a plate well-described in Mr. Newland-Pedley's paper on "Congenital Cleft" in Guy's Hospital Reports for this year. From that paper I quote the following description: "It" (Stearn's velum) "acted on the principle of a triple valve consisting of a central portion and two leaflets; the edges of the latter were grooved along their outer margins, to embrace the free edges of the cleft palate, and to glide inwards over the central portion, when the margins of the cleft approximate in deglutition."

Mr. Edwin Sercombe is the next, whose apparatus deserves mention. It is exceedingly simple, and, in fact, very closely resembles Delabarre's original plate. It consists of a plate covering more or less of the hard palate to support a sheet of soft rubber which is large enough to overlap the edges of the cleft on both sides when extended to their greatest width. The rubber is attached with silk or wire to a flange of metal projecting from the back of the dental plate. The advantage of this is that it can, if necessary, be adjusted to the mouth after being finished. It is not by any means a perfect instrument, since it depends for its movement entirely on the elasticity of the rubber curtain. This tends always to resume the flat shape, and so instead of following, as in Stearn's instrument, every movement of the soft palate, it remains as nearly flat as it can considering the pressure exerted by these parts. This strong flattening tendency, moreover, causes continual and considerable pressure on the surface which it touches, as its shape causes the edges to press harder than the rest. These must, therefore, be made very thin, to prevent unpleasantness and inflammation. The curtain is sometimes made of soft rubber specially vulcanised, between sheets of tin foil; in this case the edges can be thinned to meet the case. It is, however,

usual to make the curtain of sheet rubber, and the modes of thinning the edges are all more or less unsatisfactory. Burning the edges and wiping off the burnt material away from the plate is one way of overcoming the difficulty. It, however, leaves an unpleasant taste, and is also rough. Rubbing the edges sedulously with chloroform is said to be effective. My own slight experience is against this, and I had apparent success by the following method:—I made the curtain slightly smaller than the case warranted, and sewed it to the flange. I next cut a thick piece of rubber dam so that its edges overlapped the first piece of rubber by one-eighth of an inch, and sewed them together with finest sewing silk. The comparatively thin projecting edges of the rubber dam then formed edges of the curtain. The advantage of the Sercombe plate is that the patient can renew the curtain easily whenever necessary.

The next type chronologically, though, perhaps, the first in importance, is the Kingsley velum. It combines the best points of Sercombe and Stearn. The principle is simply that the curtain is duplicate: one (the smaller) going on the nasal side of the cleft and the other on the palatal. It thus embraces the edges of the cleft, and is moved by the movements of the muscles. The larger (palatal) curtain is attached by a hinge to a dental plate and the smaller to the centre of the larger. The shape of both may be best described as a section of a bell-shaped body, the broadest part being backwards.

One more instrument must conclude the already long, but, I fear, painfully incomplete, list of remedial apparatus. This is the Parkinson, which would, perhaps, be better called a movable obturator, since it is wholly composed of hard rubber. It consists of the inevitable hard palate having a perfectly straight posterior edge, to which is attached by means of a gold hinge another hard vulcanite plate, rounded in such a manner as to allow the soft parts to glide smoothly over it in every position. To keep this posterior plate in apposition with the soft palate, it is, however, necessary to have a light special spring fastened to the centre of its nasal surface, and running forwards to the back of the plate, covering the hard palate. As the spring lies in the cleft itself it will be seen that to prevent its attachment to the dental plate, pressing the palate and causing pain and absorption, either the dental plate must be brought back over the commencement of the cleft, or the plate cannot be used conveniently. As it cannot be made to fit and depends on mucus to supply its deficiencies in this respect, and as there are many vela which have not its several disadvantages, its one superiority, viz., its permanency, will not cause it to be often employed and it is becoming, if it is not already, obsolete.

Having decided on the apparatus most suitable for any special case, and having made one of the most perfect of its class, the Dental Surgeon will frequently be disappointed to find that patients with congenital clefts speak quite as badly after the insertion of his plate as before. This, however, is not the case with acquired clefts of short duration. The difference is easily explained. In the congenital case there are several bad habits to correct; the patient has unconsciously made every effort in his power to remedy his defect; the remaining parts of the soft palate are brought as nearly as possible together; the tip of the tongue is pressed against the lower incisors, and the base raised to close the cleft as much as possible, and the nose is used much more than normal in the formation of sounds. It is, therefore, easily to be understood that the mere insertion of a plate will not immediately cure these secondary defects, and it is only by education and perseverance that the desired result will finally ensue. It may be a matter of weeks or months, or it may be a year or more, according to the intelligence and perseverance of the patient, but if the apparatus is judiciously selected and well made, the final result is sure. As the first necessity is to distract the patient's attention from his manner of speech, frequently a vocal study with inherent difficulties is to be recommended, as for instance, singing loudly to the accompaniment of a musical instrument—loudly, as this will be more a vocal than an articulatory exercise, and, therefore, more natural. French, too being a somewhat nasal language, is suitable to be learnt by cleft palate patients, as the new sounds will be made according to the possibilities of the new palate without reference to the old habits, even though these remain in pronouncing words to which the patient is accustomed. Reading aloud to a judicious critic is advisable, special attention being paid to the lips and the position of the tongue in difficult words.

The age at which it is justifiable to deal mechanically with cleft palate depends greatly on the social position and intelligence of the patient. As a general rule it will not be wise to undertake a case until after twelve years of age—between twelve and seventeen are, perhaps, the best years. The vanity of the patient is awake and hearty co-operation is given, and yet the patient is not too old to overcome his habitual manner of speech before manhood. Though the permanent treatment of cleft palate is unadvisable before the age mentioned, it is possible to be of use to the child before it is weaned. In children with clefts there is great difficulty in sucking the teat or in taking the breast, since the act of suction implies the pressure of the teat between the tongue and palate. As this latter is deficient, it may be wise to replace it with a small piece of soft rubber. The method of doing this is to attach a suitable piece with gold wire to the ivory shield of the teat or to the nipple shield on the breast, and to introduce the palate thus formed into the infant's mouth with the teat.

In conclusion, gentlemen, I have to thank you for the kindness and attention which you have given to my paper, which I fear, though of unconscionable length, is yet all too short to deal with a subject of the magnitude of "Cleft Palate."

The CHAIRMAN congratulated Mr. Heesom on his excellent paper. He differed from him, however, in

regard to the point of heredity; he said that Professor Rose mentioned a case where cleft palate descended through four generations, also another family where it had been present for one hundred years. He used a special tray for taking impressions in nearly every case. He mentioned another method of making the apophysis as the way recommended by Mr. Heesom was liable to failure; he suggested packing the rubber round a small piece of wood charcoal or other very light substance.

The best way to trim the edges of the velum is, after baking, to go round the edges with a red-hot iron, they can then be finally smoothed with chloroform.

Mr. ELLIS asked whether adenoid growths in the palate did not interfere with hearing.

Mr. BASCOMBE thought that Mr. Heesom was rather predjudiced against surgical means of curing cleft palate. He asked if rouge assisted the setting of plaster in taking impressions.

Mr. GOADBY mentioned that adenoids occur in cases of open bite, and did not think that adenoid growths in the cleft could be called Nature's method of closing the cleft.

Mr. SNELL expressed a strong objection to the use of a spring with the velum, he said it certainly enlarged the cleft.

Mr. HEESOM having replied, a vote of thanks was passed to him for his excellent paper.

The meeting then terminated.

Pass List.

University of London, October, 1895.

M.B. EXAMINATION.

FIRST DIVISION.

Every-Clayton, L. E. V.	Salter, A.
Handley, W. S.	Thomas, T. M.

SECOND DIVISION.

Coleman, J. J.	Harnett, C. J.
Eastes, G. L.	Haylett, P. H.
Ferraby, H. P.	Hora, J.
Hardenberg, E. F. H.	Jewell, W. H.
Vellacott, P. N.	

Royal College of Surgeons, Eng., Nov., 1895.

FIRST EXAMINATION FOR THE FELLOWSHIP.

Batchelor, F. S.	Fitz-Hugh, R. T.
Bruce, H. W.	Milton, W. T.
Cleveland, A. J.	Tresidder, P. E.

EXAMINATION FOR THE LICENSE IN DENTAL SURGERY.

(Unofficial list.)

Beaumont, F. C.	Händel, F. E.
Chambers, T. R.	James, B. E.
Dawson, W. J. O.	King, H.
Denham, N.	Lewis, J. W.
Dimock, E. C.	Mathews, H. D.
Goddard, J. W.	Payne, J. L.
Ryle, A. B.	

Sport.

Association Football.

SURREY SENIOR CUP—1ST ROUND.

GUY'S v. KINGSTON-ON-THAMES.

Played at Kingston, on Saturday, November 9th, in beautiful weather, and on a ground which, considering the amount of rain during the week, was in splendid condition. Walker having won the toss, Kingston kicked off with the sun in their faces, but for the first quarter of an hour the play was very uninteresting and slightly in favour of Guy's, who had hard luck in not scoring, as the ball hit the crossbar on two or three occasions. Play then became more even, but Mandy opened our account with a lucky one—the goal-keeper missing his kick and allowing the ball to roll into the net. Ford immediately added another with a magnificent shot, the only good one during the game. After this the homesters played up hard but were unable to score, while at the other end our forwards had innumerable opportunities, but the shooting was simply disgraceful. Palmer on one occasion was less than five yards from the goal with no one to hinder him, but he skied the ball over the bar. Just before the interval Kingston were enabled to obtain their only goal through Longhurst missing his kick in front of goal—an old fault of his.

The second moiety needs little description, as our opponents were completely outplayed; in fact they crossed the half-way line only on two or three occasions. The Guy's forwards played an extremely pretty passing game, but when it came to shooting they gave the most disgusting exhibition a team could give, the majority of them evidently thinking that the uprights were placed near the corner flag, while one and all forgot that the crossbar was not more than eight feet from the ground. Towards the end of the game Humphrey scored our last goal after the ball had rebounded off the goal-keeper's knees. On time being called we left the field victorious by three to one.

Marshall, Hall and Walker were the pick of the team; the first-mentioned having improved wonderfully since the beginning of the season. The forwards gave the best exhibition of the passing game they have shown this season, but the sooner they try and find where the goal-posts are placed, and learn to shoot, especially with regard to height, the better it will be for the credit of the team and the Hospital.

We should like to state in conclusion that just *two* keen Guy's men were seen in a crowd of about 600 spectators. Team:—

GUY'S.—H. M. S. Barker (goal); G. Marshall and E. A. Longhurst (backs); R. W. Hall, F. E. Walker and H. A. Higgens (half-backs); P. S. Mandy, W. G. Palmer, G. Ford, A. Pearson, and L. Humphrey (forwards).

GUY'S HOSPITAL v. EASTBOURNE.

Played at Eastbourne on Saturday, November 16th, in beautiful weather, and resulting in a brilliant victory for the Hospital by two goals to one. Having lost the toss, Guy's kicked off against the wind; Ford, receiving a pass from Higgens, dribbled clean through his opponents, and scored in less than a minute from the start. Up till half-time the game was very even, each side attacking in turn, but the magnificent defence of the respective teams prevented any further score. On re-starting, the homesters attacked strongly, and were soon rewarded by making the scores level. After this Guy's had slightly the best of the game, but were only able to notch another point, about seven minutes from time, Ford again doing the needful. Time was soon called, giving us a most popular victory. The whole team played a splendid game; and it is hard to pick out any member who played better than his colleagues, but we should like to mention the wonderful improvement Ford has made of late; he was undoubtedly the best forward on the field, and we all hope he will keep up his form.

We were most hospitably entertained to lunch and dinner by Dr. H. J. Holman, an old member and captain of the Soccer team. Having spent a most successful and enjoyable day we wended our way to headquarters.

The following is taken from the *Sussex Daily News*:—

"While unfortunate in not winning, it was their own fault that Eastbourne lost in their fixture with Guy's Hospital on Saturday. The first goal that the visitors obtained was scored before the Eastbournians knew were they were. The simple way in which Ford dribbled the ball up to the goal without any real effort to stop him on the part of the Eastbourne men was amazing. The homesters tried to make amends for this by some sterling play, and so near were they on many occasions that it was down-right hard luck that they were unable to notch a point before half-time. They certainly had the best of the play before crossing over, the men working better together than they have done for some time past. Topham, in particular, played a brilliant game—he displayed better form than he had previously shown this season. For the first half of the second moiety they also did well, but then, for some unaccountable reason, Martin commenced toying with the ball. Twice he did it and twice he lost it, with the result that his side was so severely pressed that on the first occasion they only just managed to save, and on the second were unable to clear, this goal giving the visitors the leading point. It was so unlike Martin, and, seeing that the forwards he had to deal with were always dangerous anywhere near goal, quite inexplicable.

"Guy's Hospital had a well-balanced team, who kept going all the time, and they had in particular a couple of splendid backs and a smart and resourceful custodian. Although their forwards were a skilful lot their admirable rear division saved them from defeat. The home attack was also a bit stronger than usual, and on the whole the match was one of the most interesting seen on the Saffrons this season. Eastbourne did not play Guy's last season, but two years ago they beat them by three goals to nil, the visitors having but ten men." Team:—

Guy's.—H. M. Barker (goal); G. Marshall, E. Longhurst (backs); R. W. Hall, F. E. Walker, H. A. Higgens (half-backs); P. S. Mandy, W. G. Palmer, G. Ford, C. Higgins, L. H——— (forwards).

GUY'S HOSPITAL v. EASTBOURNE COLLEGE.

Played on the College ground on Monday, November 18th. We concluded a brilliant and enjoyable stay at Eastbourne, by beating the School somewhat easily by five goals to love, Palmer three and Ford two.

SURREY JUNIOR CUP TIE.

GUY'S 2ND XI. v. BALHAM WANDERERS.

Played at Streatham Hill on Saturday, November 16th, under rather unfavourable circumstances, resulting in the severe defeat of Guy's by seven goals to love. Our opponents were a fast lot, playing together, but on our side combination was entirely wanting; our forwards seldom troubled the Balham goal-keeper, and our backs offered no serious opposition to their attack. The only man who showed any form on our side was Thomas, in goal, and he was in no way responsible for our defeat. Team:—

Guy's: A. R. Thomas (goal); W. H. M. Smith, J. Matthews (backs); H. A. Butler, M. Thornley, H. R. Marsh (half-backs); R. G. Edey, A. A. Miller (captain), E. T. Davis, A. M. Kempe, and C. S. Brookhouse (forwards).

Rugby Football.

GUY'S 1ST XV. v. LONDON WELSH.

Played on the home ground on Saturday, November 9th, before an enthusiastic crowd of spectators. The visitors, winning the toss, elected to play towards the pavilion end, and at 3.30 Goddard kicked off for the Hospital, play settling down in the visitors' territory, where our forwards began to get the upper hand in the scrums, and were much quicker in getting the ball, but the frequent mistakes of the halves almost always caused us to lose ground when the ball came out. On the whole, however, the outside play was a decided improvement. Nearly all the pressing in the first half was done by the Hospital, and the first score to be notched was a try by Dykes, who, receiving the ball from a line out near the visitors' twenty-five, with a smart run grounded the ball over the line, the place-kick by Gwynn going wide. Soon after the drop-out the Hospital again scored: for Wetherell, obtaining the ball from some loose play in the centre of the ground, ran round the opposing players, and then, with a clever punt over the full-back's head, ran on and fell on the ball. Gwynn, with a good kick, converted. At the re-start the Welshmen showed up to more advantage, and play was for some time confined to the home twenty-five; Muriel, however, was playing a very good game at full-back for the Hospital, and stopped all rushes, nothing further being scored up to

half-time. On changing ends, matters were very even for about fifteen minutes, when the visitors began to show that they were in the better condition, and from a line out on the centre flag, Rowlands, obtaining the ball, passed back to the left wing, who had throughout been playing a good game for the visitors, and this player, with a fine run through the Hospital backs, scored near the corner flag, the place-kick going wide. The visitors continued to keep up the pressure, and scored an unconverted try, but were unable to pass the Hospital score, the game ending in a win for the Hospital by one goal and one try to two tries. Team :—

GUY'S.—G. B. Muriel (back); F. Sime, R. B. Ransford, F. C. Wetherell, F. D. S. Jackson (three-quarter backs); J. N. Gardiner and J. O. Garland (half-backs); W. Tyson, E. G. Goddard, W. P. Gwynn, F. G. Gibson, H. G. Rashleigh, P. A. Dykes, P. D. Hunter, H. V. Bagshawe (forwards).

GUY'S v. R.M.A., WOOLWICH.

This match was played at Honor Oak Park, on Wednesday, November 13th. Guy's were minus several of their backs, and this accounted for the very small amount of scoring done; the forwards played well, and gave the backs the ball very frequently, but they made but poor use of their opportunities. In the second half, Dykes obtained a try, Gwynn failing with the kick at goal. Nothing further was scored, and Guy's won by a try to nil. Team:—

GUY'S.—G. B. Muriel (back); F. L. Rae, A. C. Ransford, T. Morgan, F. D. S. Jackson (three-quarter backs); J. N. Gardiner, J. O. Garland (half-backs); E. G. Goddard, P. A. Dykes, P. D. Hunter, W. P. Gwynn, H. G. Rashleigh, M. D. Wood, E. Cohen, W. Tyson (forwards).

GUY'S 1ST XV. v. WICKHAM PARK.

Played at Honor Oak Park, on November 16th, with half a gale of wind blowing across the field. Goddard started the ball, Guy's playing uphill. The play was distinctly of the scrambling order, the wind making accurate passing quite impossible. A good run by Sime, who unluckily slipped just as he looked like scoring, was the main feature of interest. Just before half-time a very heavy shower broke over the ground, adding still further to the annoyance caused by the wind. Ends were changed with the score at "love all."

During the second half, our opponents pressed, but in spite of several free kicks awarded to them they failed to score, and the whistle blew, the final result being:—

Guy's Hospital..... 0
Wickham Park..... 0

Our forwards, who during the first half showed much improvement on their form in the earlier matches, after the interval became uncommonly slack; the halves gave the three-quarters very few chances. Muriel, at full-back, did what was set him in good style. Team :—

GUY'S.—G. B. Muriel (back); F. L. Rae, F. C. Wetherell, F. D. S. Jackson, F. Sime (three-quarter backs); J. N. Gardiner, J. O. Garland (half-backs); C. R. Nicholson, E. G. Goddard, P. A. Dykes, D. D. Hunter, W. P. Gwynn, H. G. Rashleigh, F. G. Gibson, W. Tyson (forwards).

GUY'S 1ST XV. v. CROYDON.

Played at Honor Oak on November 20th, resulting in a draw. Croydon kicked off, and pressing hard, scored a try within ten minutes of the start, but failed to convert. After this our forwards played up well, and keeping the ball well in the Croydon lines, compelled them to touch down twice. Soon after, some nice passing enabled Alexander to get in for Guy's; Gwynn did not succeed, however, in making a goal of it. From this till half-time the play was of a give-and-take description.

On change of ends, Croydon at first looked dangerous, and Muriel had to touch down. Alexander then got the ball well up to the Croydon goal line, but our forwards kicking too hard in the loose, Croydon were able to save by touching down. This was our last chance, and the play remained in the centre of the ground until the end. A hard and keenly-contested game ended with the final score :—

Guy's Hospital ... ... 3 points.
Croydon ... ... 3 points.

Team :—

GUY'S :—G. B. Muriel (back); F. L. Rae, K. B. Alexander, F. D. S. Jackson and F. Sime (three-quarter backs); J. N. Gardiner and J. O. Garland (half-backs); W. Tyson, E. G. Goddard, C. R. Nicholson, P. A. Dykes, W. P. Gwynn, H. G. Rashleigh, P. D. Hunter and F. G. Gibson (forwards).

GUY'S 2nd XV. v. LONDON & WESTMINSTER BANK

This match, played at Honor Oak on Saturday, October 26th, resulted in a win for the Bank by two goals to nil. The lack of combination forward was the main cause of our defeat; our forwards rarely got the ball, and when they did, their heeling out was much too slow.

The Bank kicked off at 3.45, and immediately attacked strongly, but good tackling by our backs—particularly by Garland and Ransford—kept them out. They, however, were not to be denied, and about ten minutes from the start, scored their first try, which was converted. Hunter kicked off, and Guy's now attacked, Garland getting the ball, passed to Kinsey-Morgan, who transferred to Bagshawe, the latter being pushed into touch close to the corner flag; Guy's now made strenuous efforts to score, but the ball was gradually worked back, and the Bank again took up the attack, being alone prevented from scoring by the splendid tackling of our backs. Nothing further was scored up to half-time, and on changing ends, Guy's again pressed, and Ransford made a good attempt to drop a goal. The Bank defended well and soon relieved the pressure, and it was now their turn to attack. From a scrum about fifteen yards from our line, Thorpe picked up the ball, and was eventually well collared in front of the posts, and within a yard of our line Kinsey-Morgan relieved by a good dribble. A lot of loose play followed, in which neither side held much advantage, but just on the call of time, the Bank scored a second and lucky try, which was converted; the game ending in our defeat by two goals to none.

Of the forwards, Hunter and Rashleigh played very well; our three-quarters had hardly any opportunities of showing what they could do in the offensive, but their tackling was very good; at half, Garland played a very good defensive game, his tackling being very effective. Team:—

Guy's.—H. W. Walling (back); E. C. Dowsett, F. D. S. Jackson, A. C. Ransford, A. Kinsey-Morgan (three-quarters); R. S. Thorpe, J. O. Garland (halves); P. D. Hunter, H. V. Bagshawe, H. G. Rashleigh, F. G. Gibson, E. Cohen, N. Williams, E. R. Rowe, F. R. Featherstone (forwards).

GUY'S 2ND XV. v. ST. THOMAS'S 2ND XV.

This match was played at Lambeth on November 2nd, and ended after a most evenly contested game in a draw of one goal each. We only played fourteen men, owing to two or three men scratching on the morning of the match. The try for us was gained by Dowsett after a fine run from nearly half-way, T. Morgan converting.

Our forwards all worked hard, Mottram being most conspicuous. Jones, at half, worked very hard; and Pern played very pluckily. Of the three-quarters, Dowsett and Kinsey-Morgan played best; Walling at full-back was as safe as usual. St. Thomas's were a very good lot forward and were slightly better than our forwards. Team:—

Guy's.—H. Walling (back); E. C. Dowsett, A. Kinsey-Morgan, H. P. Barrow, and T. Morgan, captain (three-quarter backs); M. P. Jones, and L. Pern (half-backs); G. N. Mottram, E. C. Rowe, C. Watson, Norman Williams, E. I. Spriggs, F. R. Featherstone and H. H. Bignold (forwards).

GUY'S HOSPITAL 2ND XV. v. OLD MERCHANT TAYLORS' SCHOOL.

Played at Honor Oak Park, on Wednesday, November 6th, and resulted in a win for the Hospital, after a most exciting and pleasant game, by two goals (from tries) to two goals (one from a try and a dropped goal), ten points to nine. Tries for the Hospital were gained by F. E. Walker and Gibson, T. Morgan converting. Our forwards played a good game, as also did the half-backs. Team:—

Guy's.—H. W. Walling (back); A. Kinsey-Morgan, F. D. S. Jackson, F. L. Rae, T. Morgan (three-quarter backs); J. O. Garland, F. E. Walker (half-backs); P. D. Hunter, H. V. Bagshawe, F. G. Gibson, E. R. Rowe, N. Williams, F. R. Featherstone, C. Watson, E. I. Spriggs (forwards).

GUY'S "A." v. CLAPHAM ROVERS.

This match was played at Wandsworth Common, on November 9th, and ended in a win for the Rovers by three tries to one goal and one try (nine points to eight). W. T. Clarke scored both tries, and T. Morgan converted one. Our forwards were not as good as usual, their heeling-out being very slow. W. T. Clarke played the best game on the field, his first try being the result of a very fine run. Team:—

Guy's.—H. W. Walling (back); W. T. Clarke, E. C. Dowsett, F. D. S. Jackson, T. Morgan (three-quarter backs); M. P. Jones, N. H. Pike (half-backs); A. J. Cleveland, G. N. Mottram, E. R. Rowe, N. Williams, H. Holden, F. R. Featherstone, E. I. Spriggs, H. H. Bignold (forwards).

GUY'S 2ND XV. v. BECKENHAM.

This match was played at Beckenham on Saturday, November 16th, in a perfect gale of wind. We played against the wind in the first half, and easily kept them from scoring. In the second half we were in their twenty-five nearly the whole time, and in the last fifteen minutes scored three times. The try getters were Dowsett, Barrow and Kinsey-Morgan, T. Morgan being responsible for the goals. The final result being two goals one try to nil.

The forwards played a splendid game, and gave the backs plenty of opportunities. Kinsey-Morgan and Walling, at half-back, were very well together, the latter playing an excellent half-back game. E. C. Dowsett and Barrow played well; W. G. Stewart, at full back, only touched the ball three times. Team:—

Guy's.—W. G. Stewart (back); E. C. Dowsett, A. C. Ransford, H. P. Barrow, T. Morgan (three-quarter backs); H. W. Walling, Kinsey-Morgan (half-backs); H. V. Bagshawe, E. Cohen, M. D. Wood, G. N. Mottram, E. R. Rowe, N. Williams, F. R. Featherstone, C. Watson (forwards).

United Hospitals' Hare and Hounds.

PRESIDENT:—HOWARD MARSH, ESQ., F.R.C.S.

THE opening run of this club took place on Saturday, November 9th, from headquarters, "The Royal Forest Hotel," Chingford, at 4 p.m., in conjunction with the Lea Harriers. The meeting was well attended, representatives from St. Bartholomew's, St. Thomas's, University College, St. Mary's, and Guy's Hospitals being present, and resulted in a very pleasant run of about five miles through Epping Forest. It was noticed that Guy's supplied more men than any of the other hospitals, and it is hoped that these men will take the trouble to train, as there ought to be a keen struggle for the Inter-Hospital Challenge Cup between St. Mary's, Bart.'s and Guy's in February next, the former hospital having Butler and Elwin running for them this year. Matches against the Lea Harriers, the Thames Hare and Hounds, and the Old Citizens' Hare and Hounds, are arranged, and the programme also includes three handicap races. Members of the Clubs' Union are also members of this club.

H. A. MUNRO.
R. BALDERSTON.

Marriage.

WAINEWRIGHT—BUSBY.—On the 30th October, at St. Cuthbert's Church, Kensington, by the Rev. William Busby, brother of the bride, assisted by the Rev. Bernard Steinmetz, Robert Spencer Wainewright, M.D. Lond., youngest surviving son of the late John Wainewright, Senior Taxing Master in the High Court of Chancery, of Belmont, Lee, Kent, to Emily Blanche, third daughter of the late Alexander Busby, of Cassilis, New South Wales, and Mrs. Busby, 30, Nevern Mansions, Earl's Court, S.W.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold, will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

DECEMBER 7, 1895.

A Call to Arms!

GUY'S HOSPITAL is an ancient institution; it is distressed by the depreciation which time has wrought upon the value of its endowments in agricultural land, but it is not moribund. In June last, the Governors, finding themselves confronted by a yearly deficit of about twenty thousand pounds on the assured income, made a formal announcement of the fact, and created a special department for the purpose of securing public support. Since then the Hospital is richer by some fourteen thousand pounds. Its cause has been eloquently pleaded by the most prominent statesman and striking personality of the century; co-operation and assistance have been forthcoming, or are promised, from a host of those having ties to the place; the musical talent of the Students will be devoted to an important series of entertainments after Christmas to be given in the interests of the Hospital; the employees of our neighbours—the South-Eastern Railway Company—are generously working might and main in the same cause; the Lady Pupils are organising their forces for great efforts in the New Year, when a leading dramatic club will also entertain the West End on our behalf; and last, but not least, among the varied agencies from which help should be assured, His Royal Highness the Prince of Wales will preside, in May next, at the First Festival Dinner of Guy's Hospital.

Now this is a splendid start, which has not been attained without much toil, and for which hearty thanks are due to all concerned, but it is only a beginning, and one that will not be maintained without the exercise of that rare characteristic—steady and continuous effort. However hard the authorities may work, they look for and require the aid of every possible helper, no matter how humble so long as sympathy is not lacking. So, by the help of many friends—great and small—working in a variety of ways, a sum sufficient to keep the old place going may be forthcoming annually until its re-endowment is an accomplished fact. This question of re-endowment tends to enter the sphere of practical politics. It is true that the obtaining of five hundred thousand pounds for permanent investment is a task appalling to the imagination—and we have nothing to lead us to believe that it is on the way in one magnificent donation, but, as will be seen in another column, a germ exists which, it is reasonable to believe, will grow: for the idea of having their donations invested for the permanent benefit of the Hospital will surely arrest the attention of some who will be pleased to realise that the benefits of their charity are not merely ephemeral, and will also attract the notice of others who prefer the established to the voluntary principle.

We venture to prophesy that the Sustentation Fund will succeed. Granted that Guy's as a Hospital continues to deserve success; that it never fails to perform with wisdom, skill and sympathy the noble duties for which it was called into existence—then this Fund must succeed, because of the attractions it presents to generous and philanthropic minds. For what form of public activity, over and above the elementary necessity of earning our daily bread, is so beneficent, so indispensable, so rich in results, so honouring to humanity, so little prone to excite animosity, as the relieving of human suffering? To engage in strictly

religious enterprise, in political life, in educational advancement, in social reforms, is to meet opposition and misrepresentation at every step, to find one's ideas seemingly impossible of attainment; but to provide the means for the relief of pain and sickness, is to secure universal commendation, and to bestow immediate and lasting benefits. All this may sound like a truism, but it is one so far forgotten as to make many unable to recognise the much less exalted truth that Medical Schools and Hospitals must stand or fall together, and that no scientific skill can be forthcoming at the command of the rich if the wards are not full of the poor. No such reproach attaches to Guy's people, but we sincerely hope that the particulars we now publish of what has been accomplished may be the inspiration of even greater deeds and far wider activity. To every willing helper will be due the honour of having shared in the work of perpetuating the noblest charity of any single individual since mediæval times—the Hospital of Thomas Guy, and his monument will be theirs also.

Guy's Hospital Sustentation Fund.

£20,000 ANNUALLY REQUIRED.

Under the will of its founder, Thomas Guy, the whole of the property of the Charity was compulsorily invested in landed estate. Owing to agricultural depression, the annual income has now fallen from £40,000 to £20,000.

To avoid the grave calamity of having to close several hundred beds and curtail by one half the various useful agencies at work in connection with the Hospital, it is necessary that the yearly deficit of about £20,000 should be met by voluntary subscription.

In answer to the appeal recently issued by the Governors, and supported by Mr. Gladstone's letter, which appeared in the public Press on October 30th, the following subscriptions have been secured, up to and including November 30th, 1895.

Further contributions will be gratefully acknowledged by the Treasurer, at the Hospital, Southwark, S.E.; or may be sent direct to the Hospital's Bankers, Messrs. Lloyds & Co., 72, Lombard Street, E.C.

	£	s.	d.
Rt. Hon. W. E. Gladstone	50	0	0
Subscribed by Present Students, Old Guy's Men and Personal Friends of the late Arthur Edward Durham, F.R.C.S., sometime Senior Surgeon of Guy's Hospital, to endow two Beds in his memory ...	2,000	0	0
*Cohen, A. L., Esq. (to endow a bed in memory of H. A. Cohen)	1000	0	0
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Druce, Miss F.	10	0	0
Druce, Miss E. C.	10	0	0
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Nesbitt, Messrs. A. & W.	5	5	0
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Moore, Miss Julia	5	5	0
Stuart, J., Esq.	5	5	0
Fry, T. H., Esq. (ann.)...	5	5	0
Fisher, H., Esq....	5	5	0
De Wesselow, G. F. S., Esq.	5	5	0
Ness, Patrick, Esq.	5	5	0
Wood, Mrs. J.	5	5	0
Nelson, Dale & Co., Lim., Messrs. G. ...	5	5	0
Gross, Mrs.	5	5	0

	£	s.	d.
Edwards, Mrs., per Dr. Forty...	5	5	0
Aston, Theodore S., Esq., Q.C., per Dr. Blatherwick	5	5	0
Schmittau, H., Esq., per Dr. Blatherwick ...	5	5	0
Allen, G. W., Esq.	5	5	0
Richards, G. O., Esq.	5	5	0
Bawn, W. B., Esq.	5	5	0
Barron, The Misses (ann.)	5	5	0
Kœnig, H. H. & F. A., Esqs. (ann.)	5	5	0
Perkins, Sir Fredk., per Dr. Blatherwick ...	5	5	0
Warren, T. P., Esq.	5	5	0
Lowenfield, H., Esq.	5	5	0
Cock, F. W., Esq., M.D.	5	5	0
Early, C., Esq.	5	5	0
Manning, E. T., Esq.	5	5	0
Evans, John, Esq., per H. Williams, Esq. ...	5	5	0
Palmer, C. H., Esq.	5	5	0
Cook, Son & Co., Messrs. (ann.)	5	5	0
Morris, E. R., Esq., per F. E. Walker, Esq.	5	5	0
Leaf, F. Walton, Esq.	5	5	0
Patterson, E. C., Esq.	5	5	0
G. W. R. Medical Fund Society (ann.) ...	5	5	0
P. H.	5	5	0
Hargraves, E. T., Esq.	5	5	0
Clive, Gen. E. H. (ann.)	5	5	0
Powell, F., Esq.	5	5	0
Monument Bonded Warehouses Co.... ...	5	5	0
Christopher, J. T., Esq.	5	5	0
Curriers' Company, The	5	5	0
Draper, A. C. S., Esq.	5	5	0
Huntington, E. C., Esq.	5	5	0
Thorne, Everard, Esq., per Mrs. F. Taylor ...	5	5	0
Goldsmiths' and Silversmiths' Co. do. ...	5	5	0
E. K.	5	5	0
Beddome, Col.	5	5	0
Hayes, E., Esq., per Sister Ruth	5	5	0
Pollock, G. F., Esq.	5	5	0
Knight, Messrs. R. A. & Co. (ann.)	5	5	0
Grattan, H. H. G., Esq. (ann.)	5	5	0
Martin, H. A., Esq (ann.)	5	5	0
Bisshopp, J., Esq.	5	5	0
Wells, W. G., Esq. (ann.)	5	5	0
Friendly Society Parade, Bexley Heath ...	5	2	8
Prier, S., Esq., M.D.	5	0	0
Cheeseman, J., Esq.	5	0	0
Sykes, Major Cam (ann.)	5	0	0
Egerton, Admiral the Hon. F.	5	0	0
Jones, W. A., Esq.	5	0	0
Goldie, Miss M. L.	5	0	0
Parker, Miss Amy	5	0	0
Nicholls, E. W., Esq.	5	0	0
Do. do. (ann.)	2	2	0
Anonymous	5	0	0
Edgington, Benjamin, Limited	5	0	0
Newton & Sons, Messrs. J.	5	0	0
N. W. E.	5	0	0
Searle, Mrs.	5	0	0
Astell, Mrs.	5	0	0

	£	s.	d.
Proctor, Mrs.	5	0	0
Smith, Miss A.	5	0	0
Ramsden, Miss	5	0	0
Guy, Thos., Esq.	5	0	0
Noble, Wilson, Esq.	5	0	0
Noble, Mrs.	5	0	0
Furlong, Mrs. M.	5	0	0
Fawcett, Miss L. (ann.)	5	0	0
Ferard, J. E. Esq. (ann.)	5	0	0
Bayliss, W. M., Esq. (ann.)	5	0	0
Hoare, H. E., Esq.	5	0	0
Currie, Miss Gore	5	0	0
Ames, Mrs. Lionel	5	0	0
Barbour, Geo., Esq.	5	0	0
Wheeler, A. L., Esq.	5	0	0
Moore, Miss Mary C.	5	0	0
Leaf, A. A., Esq.	5	0	0
Ewart, Miss Mary Anne	5	0	0
Dawson, John, Esq.	5	0	0
Gasselee, H., Esq.	5	0	0
Snelgrove, A. R., Esq.	5	0	0
Veasey, A., Esq.	5	0	0
Malet, Sir E.	5	0	0
Minns, Pembroke, Esq., M.D.	5	0	0
Francis, H. R., Esq.	5	0	0
Leaf, Mrs. Emma (ann.)	5	0	0
Gilmour, Capt. R. G. (ann.)	5	0	0
Acland, C. T. D., Esq. (ann.)	5	0	0
Lawrence, A. J., Esq. (ann.)	5	0	0
Blackwell, Mrs.	5	0	0
Blackheath Football Club	5	0	0
Clague, John, Esq.	5	0	0
Harben, H., Esq., per Mrs. F. Taylor	5	0	0
Harben, Miss do.	5	0	0
Horne, Edgar, Esq. do.	5	0	0
Walton, The Misses, per A. Josephs, Esq.	5	0	0
Arbuthnot, H. L., Esq.	5	0	0
Grenfell, C. S., Esq.	5	0	0
Smith, Hon. Miss, per C. A. Aikin, Esq.	5	0	0
Gough, B. B., Esq.	5	0	0
Campion, C. W., Esq.	5	0	0
Cotterill, H., Esq.	5	0	0
Lane, Mrs. B.	5	0	0
"Roucy"	5	0	0
Hessey, Mrs.	5	0	0
Gore, Francis C., Esq.	5	0	0
Goldschmidt, A. B. H., Esq.	5	0	0
C. A. P.	5	0	0
Romaine, W. C., Esq.	5	0	0
McKewan, W., Esq.	5	0	0
Astell, W. H., Esq.	5	0	0
Bisshopp, F. R. B., Esq., M.D.	5	0	0
Lawrence, Miss E.	5	0	0
Palmer, W. J., Esq., M.D.	5	0	0
Butler, Miss Elinor D.	5	0	0
Zanchi, V. B. M., Esq.	5	0	0
Shaw, Major	4	19	2
Collected at Smoking Concert in Guy's Hospital College	4	10	0
Dawes, Mrs., per Sister Ruth	4	4	0
Peck, Miss Alice, per J. A. Reaside	4	4	0
Weaver, F. P., Esq., M.D.	4	4	0
Farrar, Mrs. Bryan	4	4	0
Rubinstein, D., Esq., M.D.	4	1	3
Landon, W., Esq.	4	0	0
B. A., Cantab	3	7	6
Standard Bank of South Africa, Ltd., London Staff of, per Dr. A. P. Allan	3	5	0
Buxton, Francis, Esq.	3	3	0
Henlé, Louis A., Esq	3	3	0
Young, G. A., Esq.	3	3	0
Charlesworth, W. H., Esq.	3	3	0
Westbury, Lady (ann.)	3	3	0
De Rothschild, Mrs. Leopold	3	3	0
Maxim-Nordenfelt Gun Co., Staff and Employees of	3	3	0
Wilman, Arthur, Esq., M.A.	3	3	0
Wilson, G. F., Esq.	3	3	0
Taylor, G. Noble, Esq. (ann.)	3	3	0
Christopher, J. T., Esq. (ann.)	3	3	0
Hoatts, R. J., Esq.	3	3	0
Millar, W. R., Esq. (ann.)	3	3	0
Norris, Mrs.	3	3	0
Hills, W., Esq., per H. Williams, Esq.	3	3	0
Aikin, C. A., Esq. (ann.)	3	3	0
R. W.	3	3	0
Millar, W. R., Esq. (ann.)	3	3	0
Marshall, Jas. A., Esq. (ann.)	3	0	0
Askew, Mrs.	3	0	0
Leaf, Miss Mary T.	3	0	0
Lake, The Very Rev. Dean	3	0	0
Leaf, Rev. W.	3	0	0
Fry, Sir Edward	3	0	0
Bowstead, Mrs.	3	0	0
Williams, Miss Alice	3	0	0
Holmes, Mrs. M.	3	0	0
Portal, R. P., Esq., per Mrs. F. Taylor	3	0	0
Lamb, W. H., Esq., M.D.	2	12	6
Perkins, G. Steele, Esq., M.B.	2	2	0
Butler, Miss	2	2	0
Growse, Wm., Esq.	2	2	0
Hopkins, A. A., Esq. (ann.)	2	2	0
Nisbet, Col. R. P. (ann.)	2	2	0
Swift, Miss S.	2	2	0
Wests' Brewery Company, Limited	2	2	0
Black, James Tait, Esq.	2	2	0
Harley, F., Esq.	2	2	0
Hirsch, Mrs. L. (ann.)	2	2	0
Winchelsea, Dowager Countess of (ann.)	2	2	0
Osborn, A. G., Esq.	2	2	0
Owen, Douglas, Esq.	2	2	0
Fawcett, R. A., Esq. (ann.)	2	2	0
Ward, John, Esq.	2	2	0
Lacey, T. Warner, Esq.	2	2	0
Baxter, F., Esq.	2	2	0

	£	s.	d.
Greaves, E. H., Esq.	2	2	0
Anonymous	2	2	0
Allport, W. M., Esq.	2	2	0
Walker, J. J., Esq., per F. E. Walker, Esq.	2	2	0
Earle, C. W., Esq. (ann.)	2	2	0
Harries, Wilkinson & Raikes, Messrs. (ann.)	2	2	0
M. W., per T. Bryant, Esq.	2	2	0
Rose, J. W., Esq. (ann.), per Dr. Blatherwick	2	2	0
Stanley, W. F., Esq. (ann.)	2	2	0
Collison, Mrs. (ann.)	2	2	0
Fitch & Son, Messrs. (ann.)	2	2	0
Barker & Co., Messrs. (ann.)	2	2	0
Leng, J. A. W., Esq. (ann.)	2	2	0
Ash, Messrs. Claudius, & Sons (ann.), per Dr. Starling	2	2	0
Anderson & Cattley, Messrs. (ann.)	2	2	0
Green, T. G., Esq. (ann.)	2	2	0
Arthur, J. R., Esq.	2	2	0
Appleton, Machin & Smiles, Messrs.	2	2	0
Ogilvie, R. A., Esq.	2	2	0
Cooper, Mrs. S. M. (ann.)	2	2	0
Scammell, Mrs.	2	2	0
Riddle & Couchman, Messrs., Employees of, (second donation)	2	2	0
Coward, Rev. R. J.	2	2	0
Holman, H. J., Esq.	2	2	0
Dunne, Gen. J. H.	2	2	0
Anonymous, per Mrs. F. Taylor	2	2	0
Edwards, Mrs. E. T., per Dr. Blatherwick	2	2	0
Barry, J. H., Esq. do.	2	2	0
King, Mrs. Harriet do.	2	2	0
Gardiner, R. S., Esq., per A. Josephs, Esq.	2	2	0
Allen, R. C., Esq.	2	2	0
Whatley, A. T., Esq. (ann.)	2	2	0
Fortescue-Brickdale, Mrs. (ann.)	2	2	0
Hale, Mrs. A. Creighton	2	2	0
May, Messrs. R., & Son (ann.), per Dr. Blatherwick	2	2	0
Worts, S. E., Esq. (ann.)	2	2	0
Worts, S., Esq. (ann.)	2	2	0
Maggs, W. A., Esq. (ann.)	2	2	0
Cressy, A. Z. C., Esq. (ann.)	2	2	0
Garrett, A. E., Esq. (ann.)	2	2	0
Wileman, Joseph, Esq.	2	2	0
A Friend	2	2	0
Mountain, Mrs.	2	2	0
Perry, J. J., Esq.	2	2	0
Edwards, Mrs. E. R.	2	2	0
Pender, T. D., Esq.	2	2	0
Curry, Rev. J. G., and Mrs.	2	2	0
Edgecumbe, Miss Maud	2	2	0
Drew, Mrs. Francis	2	2	0
Smart, G. F., Esq.	2	2	0
Nelson, H., Esq.	2	2	0
Godden, Mrs. Wilfred (ann.)	2	2	0
King, Zeph, Esq.	2	2	0
Sutton, Mrs., per Mrs. F. Taylor	2	2	0
Wright-Anderson, Mrs. (ann.)	2	0	0
Eden, Colonel W. T.	2	0	0
Carte, R. D'Oyly, Esq.	2	0	0
Gott, Rev. C. R.	2	0	0
Harben, Mrs., per Mrs. F. Taylor	2	0	0
Stirling, Lady Caroline	2	0	0
Chalmers, Mrs.	2	0	0
Portal, W. R., Esq.	2	0	0
Fenwick, P., Esq.	1	15	8
Cohicher, S., Esq.	1	11	6
Rogers, M., Esq.	1	10	0
Anchor Brewery Lecture Room (Collection)	1	3	6
Nightingale, W., Esq.	1	1	0
Stevenson, F. S., Esq., M.P.	1	1	0
Wells, Mrs. Susannah	1	1	0
Neate, Rayner M., Esq.	1	1	0
Swinton, G. H. T., Esq.	1	1	0
Loveridge, R., Esq.	1	1	0
Vaughan, Rev. W. A.	1	1	0
Clarke, J. C., Esq. (ann.)	1	1	0
Creuse, Arthur E., Esq. (ann.), per Miss Leng	1	1	0
Nathan, Mrs. Louis (ann.)	1	1	0
Moggridge, Miss S. D. (ann.)	1	1	0
Fletcher, —., Esq., per Sister Ruth	1	1	0
Hodgson, J. B., Esq.	1	1	0
Hodgson, Mrs. G.	1	1	0
Wilks, A. S., Esq.	1	1	0
Allan, G., Esq.	1	1	0
Locock, Miss (ann.)	1	1	0
Briscoe, J. F., Esq. (ann.)	1	1	0
Bennett, Miss, per Sister Ruth	1	1	0
Tribe, J. R., Esq.	1	1	0
Mankiewicz, F. J., Esq.	1	1	0
Chandler, F. L., Esq., per Dr. A. P. Allan	1	1	0
Pitt, Miss Ellen (ann.)	1	1	0
Norris, H. L., Esq.	1	1	0
Pass, Mrs. John de	1	1	0
Jarrett, F. C., Esq., per H. Williams, Esq.	1	1	0
Anderson, F., Esq. do.	1	1	0
Nesbitt, Mrs. C. H.	1	1	0
Fleuret, J. B., Esq.	1	1	0
Turner, J. Sidney, Esq. (ann.)	1	1	0
Haigh, W., Esq. (ann.)	1	1	0
Hugill, G. F., Esq. (ann.)	1	1	0
Jones, Miss Victoria (ann.)	1	1	0
Chapman, George, Esq. (ann.)	1	1	0
Sangar, Chas., Esq. (ann.), per Dr. Starling	1	1	0
Ash, W. H., Esq. (ann.) do.	1	1	0
Henderson, Mrs. M. C. (ann.)	1	1	0
Steele, Kenneth, Esq. (ann.)	1	1	0
London Soap and Candle Co.	1	1	0
Bradford, Mrs. Katherine M.	1	1	0
Fearnsides, J. W., Esq.	1	1	0
Kemp, G. Lajus, Esq., M.D. (ann.)	1	1	0
A Friend, per Dr. Kemp (ann.)	1	1	0
Griffiths, Harold, Esq.	1	1	0
Ransom, F., Esq. (ann.)	1	1	0

	£	s.	d.
Anderson, Dr.	1	1	0
Allan, Murdoch S., Esq. (ann.)	1	1	0
Hinton, J., Esq.	1	1	0
Rowe, George J., Esq. (ann.)	1	1	0
Barry, R. M. Otter, Esq.	1	1	0
Blundell, Col. H.	1	1	0
Waddy, H. E., Esq., per Mrs. F. Taylor ...	1	1	0
Hampton & Sons, Messrs. do. ...	1	1	0
Cæsar, J. T., Esq., per Dr. Blatherwick ...	1	1	0
Anonymous do. ...	1	1	0
Jeffery, J. W., Esq., per A. Josephs, Esq. ...	1	1	0
Maxwell, Miss (ann.)	1	1	0
Major, H. G. F., Esq. (ann.)	1	1	0
Nicholls, T. A., Esq. (ann.)	1	1	0
Cerjat, Mrs. Helen de (ann.)	1	1	0
Hopkins, Mrs. W. B. (ann.)	1	1	0
Russell, J. W., Esq., M.D. (ann.)	1	1	0
Abbott, T. W., Esq. (ann.)	1	1	0
Smith, John, Esq. (ann.)	1	1	0
Henson, W. J., Esq. (ann.)	1	1	0
Paget, P., Junr., Esq. (ann.)	1	1	0
Bodmer, R., Esq. (ann.)	1	1	0
Green, W. H., Esq.	1	1	0
Allan, M. S. (ann.)	1	1	0
Field, T., Esq. (ann.)	1	1	0
Cuff, H. E., Esq., M.D. (ann.)	1	1	0
Adeney, E. L., Esq., M.D.	1	1	0
Pare, J. W., Esq., M.D. (ann.)	1	1	0
Ginterman, G., Esq.	1	1	0
"Persis"	1	1	0
Layman, E. B., Esq.	1	1	0
Chandler, P. W., Esq.	1	1	0
Stuart, Mrs. K. B.	1	1	0
Macdonald, P., Esq.	1	1	0
Johnson, Mrs. E. S. (ann.)	1	1	0
Burroughs, J. E. B., Esq.	1	1	0
Mugford, S. A., Esq., M.D.	1	1	0
Humphreys, W., Esq.	1	1	0
Lewis, Mrs. F., per Mrs. F. Taylor	1	1	0
Way & Sons, Messrs., per Mrs. F. Taylor ...	1	1	0
Van Abbott, Esq. (ann.)	1	1	0
Slipper, Miss	1	0	0
Stovin, Mrs., per Sister Ruth	1	0	0
Ward, Admiral	1	0	0
Powrie, W., Esq.	1	0	0
Baass, G. R., Esq., per Dr. A. P. Allan ...	1	0	0
Sharp, Capt.	1	0	0
Conford, Mrs L.	1	0	0
Heberden, Col. H.	1	0	0
Low, The Misses	1	0	0
Leitrim, Countess of	1	0	0
Bold, W. R., Esq.	1	0	0
Hake, Miss	1	0	0
M. P.	1	0	0
Chaplin, Mrs.	1	0	0
Parker, W. H., Esq.	1	0	0
Berry, Hy., Esq., per Mrs. F. Taylor ...	1	0	0
Phipps, Mrs., per F. E. Walker, Esq. ...	1	0	0
Phipps, Miss do.	1	0	0
Wightman, J., Esq.	1	0	0
Wightman, Miss	1	0	0
Wightman, Miss J. A.	1	0	0
Lees, H. E., Esq.	1	0	0
Hayes, T. E. D., Esq.	1	0	0
Keighley, Thos. B., Esq., per Sister Ruth ...	1	0	0
Houlton, Sir Ed. V.	1	0	0
Moore, T. A., Esq.	1	0	0
Richardson, H., Esq.	1	0	0
Beavis, C., Esq.	1	0	0
Kennedy, General	1	0	0
Sums under £1	15	2	4

* These sums will be permanently invested at the request of the donors.

SCHEME FOR THE RE-ENDOWMENT OF GUY'S HOSPITAL.

£500,000 REQUIRED.

Certain of the donations included in the foregoing list have been given on the express condition that they be invested for the permanent benefit of the Hospital. These are :—

	£	s.	d.
Subscribed by present Students, old Guy's Men, and Personal Friends of the late Arthur Edward Durham, F.R.C.S., sometime Senior Surgeon of Guy's Hospital, to endow two Beds in his memory ...	£2000	0	0
A. L. Cohen, Esq. (to endow a Bed in memory of his son, H. A. Cohen)... ...	1000	0	0
G. C. Raphael, Esq.	200	0	0
The Proprietors of Butler's Wharf	100	0	0
The Employees of Butler's Wharf	33	14	0
	£3,333	14	0

This forms the nucleus of a Re-endowment Fund, to which will be added all sums received under similar conditions.

At present £1,000 will endow a bed, and £500 a child's cot in perpetuity. If desired, endowed beds and cots will be indicated in the wards by a tablet, brass plate, or otherwise.

For the guidance of those who may wish to leave a legacy to the Hospital, and for the avoidance of doubts and litigation, it may be well to state that the Governors of Guy's Hospital are incorporated under special Act of Parliament as "The President and Governors of the Hospital founded at the sole costs and charges of Thomas Guy, Esquire." A legal form of bequest will be sent on application to the Treasurer. Executors may exercise the same privileges as would have belonged to the testator had the bequest to the Hospital taken effect during his life.

ASSOCIATION OF OLD GUY'S MEN.

(Formed to assist the Hospital in the present crisis.)

The following is a list of names received up to the time of going to press:—

President: Samuel Wilks, Esq., M.D., LL.D., F.R.S.

Abbott, G., Tunbridge Wells
Adeney, E. L., M.D., Tunbridge Wells
Aikin, W. A., M.D., Sumner Place, S.W.
Airy, Hubert, M.D., Woodbridge
Allan, A. P., M.B., Croydon
Allport, A., Milk Street, E.C.
Arminson, W. B., M.D., Lytham
Armitage, S. H., M.D., Tatham
Anderson, James, M.D., Hampstead
Bailey, H. B., M.D., Worthing
Baldwin, F. B. Judge, Rotherham
Ball, J. A., M.B., Bromsgrove
Bampfylde, J., Jersey
Barnes, W. E. G., Paddington
Barrett, A. E., Addison Terrace
Barrs, A. G., M.D., Leeds
Bartlett, H., M.D., West Norwood
Beale, E. Clifford, M.B., Kensington
Beard, F., M.B., Croydon
Beeby, W. T., M.D., Bromley
Berry, H. Poole, M.B., Grantham
Bevan, R., Lydd
Biddle, H. G., Broadstairs
Biggs, J. J. E., Cardiff
Birdwood, G. T., Maida Vale
Bisshopp, F. R. B., M.D., Tunbridge Wells
Bisshopp, James, Tunbridge Wells
Blatherwick, H., Dulwich
Blenkarne, W. L'H., Leicester
Boger, W. H., Fowey
Bollan, C., Oxted
Bolton, Frank R., Edgbaston
Booth, J. H., Chesterfield
Bowden, G. H., Reigate
Bowen, O., Everton
Bowen-Jones, L. M., Carmarthen
Bowes, John, Herne Bay
Bremner, R. A., Exeter
Brett, A. T., M.D., Watford
Bright, John M., M.D., Forest Hill
Briscoe, J. F., Alton
Brodrick, C. C., Tavistock
Brogden, R. W., M.B., Ipswich
Brookhouse, C. T., M.D., Brockley
Brooks, Bramsby, Sonning
Browning, W., Weymouth
Bunting, J., Earlham, Torquay
Cadell, N. P., Tiverton
Caldecott, C., M.B., Bracknell
Cameron, W. Sinclair, Gray's Inn Road
Carden, W. A., Rotherhithe
Carey, F. E., M.D., Guernsey
Carling, W., M.B., Southsea
Carter, T., Richmond, Yorks
Chaplin, T., M.D., Anerley Park
Cheesman, J., M.D., Buckingham
Chittenden, J. F., M.D., Dover
Chubb, W. L., Sandgate
Churchward, A., M.D., South Norwood
Clague, J., Isle of Man
Clapham, C., M.D., Rotherham
Clark, W., Norwood
Clarke, H., Wakefield
Clarke, J. St. T., M.D., Leicester
Clarke, J. C., Morley
Clegg, W., Boston
Clowes, N. B., Reading
Coleman, F. J., M.D., Wakefield
Collins, H. A., Saxmundham
Collins, H. W., Wrington
Colquhoun, W. B., Sandhurst
Connolly, B. Bloomfield, M.D., Lewisham
Cooke, T. A. B., New Milford
Cookson, S., M.D., Stafford
Coombe, F. Orloff, North Walsham
Coombe, T. S., B.A., Purton
Cooper, H., M.B., Surbiton Hill
Counsell, H. E., F.R.C.S., Liss
Creasy, R., Windlesham
Creed, C. P., West Kensington
Cregeen, J. N., Liverpool
Cressy, A. Z. C., Wallington
Crew, J., J.P., Higham Ferrars
Crook, H. E., M.D., Margate
Crossley, Chas., J.P., Leicester
Cuff, R., M.D., Scarborough
Daglish, R. R., J.P., New Romney
Daldy, A. M., M.D., Kingston-on-Thames
Dalton, B. N., M.D., South Norwood
Davies, A., M.D., Maindee
Deane, A. D., Walthamstow
Deane, E., Caversham
De'Ath, G. H., Buckingham
Deeping, G. D., Southend
Dixon, G. F., Tyldesley
Donnelley, W. T. B., M.B., New Cross
Duke, B., Clapham Common
Duke, E., St. Leonards
Eastes, T., M.D., Folkestone
Elliott, E., Wolverhampton
Emmet, J. W., Bexhill-on-Sea
Emms, A. Wilson, J.P., Leicester
Ellerton, J., M.D., Middlesbrough
Elphinstone, R., Towcester
Evans, J. R., Dowlais
Evans, J. H., Liverpool
Evans, R. D., Dowlais
Evershed, A., Fishbourne
Evershed, A. R. F., Penzance
Ewen, H. W., East Cowes
Fagge, F. T., Llanfairfechan
Faraker, J. J., Esq., Rotherhithe
Farmer, F. R., Harringay
Farr, E. A., Andover

Fisher, T., M.D., Clifton
Forman, E. B., M.D., South Kensington
Forty, D. H., Wotton-under-Edge
Foster, O. H., M.B., Hitchin
Fotherby, H. I., M.D., Reigate
Fowke, F. W., Byfield
France, J. F., F.R.C.S., Westbourne Grove
Frith, W. S., M.B., Rickmansworth
Fyson, E. L., Newmarket
Gaitskell, E. F., Sydenham
Galton, J. H., M.D., Norwood
Galton, E. H., F.R.C.S., Brixton Hill
Garrard, W. A., Rotherham
Gathergood, B. W., M.D., Terrington St. John's
Gay, J. H., Spilsby
Gibson, J. H., Aldershot
Girling, C. J., M.B., Birstall
Goodall, E., M.D., Carmarthen
Gorham, John, Tonbridge
Graves, C. H., M.D., Stafford
Greaves, E. H., Amersham
Green, A., M.B., Chesterfield
Green, G. R., Ripon
Greenwood, E. Climson, St. John's Wood
Griffiths, J. B., St. Ives
Growse, W., Kenilworth
Guy, Thomas, M.D., Dover
Gwatkin, O., Grange-over-Sands
Hall, J. G., J.P., Swansea
Harris, R., M.B., Southport
Harsant, W. H., F.R.C.S., Clifton
Hartree, J. P., M.B., Leigh, Tunbridge
Hayward, J. W., Whitstable
Hayward, M. P., Cheltenham
Hetley, H., M.D., Upper Norwood
Hibberd, E., M.D., Elgin Avenue, W.
Hibberd, H. J., Brockenhurst
Hickman, H. V., M.B., Wanstead
Hicks, R., Ramsgate
Hills, A. P., Battersea Park
Hinton, H. T., M.B., Heytesbury
Hinton, J., Batheaston
Hodgson, H., M.B., Blisworth
Holman, F. K., South Hampstead
Holman, H. C., East Hoathley
Holman, H. J., Eastbourne
Holman, R. C., Midhurst
Hooper, C., Southampton
Hooper, D., M.B., Trinity Square, S.E.
Howell, T. A. I., Wandsworth
Hugill, G. F., Balham
Hyne, F. A., St. Mawes
Ince, J., Surgeon Lieutenant-Colonel, M.D., Swanley
Jalland, H. W., F.R.C.S., York
Johnson, D., M.D., Tulse Hill
Jones, G. M., Alton
Jones, B., M.D., Leigh, Lancashire
Jordison, C., Malpas
Keiffenheim-Trubridge, L. W., M.D., Hoo
Kellock, W. B., M.D., Stamford Hill
Ker, H. R., F.R.C.S., Balham
Key, D. T., Reading
King, C., Highbury Park
Kingsford, E. C., Brondesbury
Kinsey-Morgan, A., M.D., Bournemouth
Knaggs, R. Lawford, M.D., Leeds
Lacey, T. Warner, Woolwich
Landon, E. E. B., Woodford Green
Lang, E. Jackson, 38, Old Bond Street, W.
Lansdale, W., M.D., Trinity Square, S.E.
Latimer, H. A., M.D., Swansea
Lee, C. G., Liverpool
Lipscomb, E. R. S., Starcross
Locke, Surg. Lieut.-Col., Coatham
Lockhart, W., F.R.C.S., Blackheath
Lockyer, G. E., Barnard Castle
Logan, F. G. B., Bristol
Love, A. E. B., Bournemouth
Lucas, H., Huntingdon
MacIlwaine, S. W., South Petherton
Mansell, E. R., Hastings
Manser, F., Tunbridge Wells
Marshall, E. W., Mitcham
Marshall, W. L. W., Huddersfield
Martin, H. A., London
Martin, J. P., Box
May, E. H., Pentonville Road, N.
Meek, J. W., M.D., Herne Hill, S.E.
Mesquita, S. B. de, M.D., Highbury New Park
Metcalfe, G. H., Clare, Suffolk
Milne, A., M.B., Sheffield
Milward, J., M.D., Cardiff
Minns, P., M.D., Thetford
Mondelet, W. H., M.D., Brighton
Munden, C., Ilminster
Muriel, G. J., Whitehaven
Murphy, Shirley F., Tavistock Square
Muspratt, C. D., M.D., Bournemouth
Nash, N. G., Welford
Nason, J. J., M.B., Stratford-on-Avon
Nattrass, C., M.D., Sunderland
Neale, B. G., Redland, Bristol
Newnham, C. A., Wolverhampton
Newnham, W. H. C., M.B., Clifton
Nunneley, J. A., M.B., Leeds
Oram, R. R. W., Wandsworth Common
Orme, R., Leigh, Essex
Osborn, A. G., Dover
Ouston, T. G., F.R.C.S., Newcastle-on-Tyne
Packer, H. D., Beverley
Palmer, A. E., Loughborough
Pantin, C. S., M.D., Douglas
Pare, J. W., M.D., Portland Place
Parke, C. J., Brockley
Parkinson, C. H. W., Wimborne
Pearse, E. S., Brierley Hill
Pendlebury, J. P., Ormskirk
Perkins, Whitfield, M.D., Port Isaac
Phillips, G. Turner, J.P., Palace Court
Phillips, H. A., M.D., Gravesend

Phillipps, W. A., M.D., Mayfair, W.
Pilkington, Sir G. A., Southport
Pittock, G. M., M.B., Margate
Pollard, G. F., Liverpool Road
Pope, E., Tring
Potts, T. R. H., Amersham
Price, A. E., M.D., Bromley
Pritchard, E. J., M.B., Hinckley
Pye-Smith, R. J., F.R.C.S., Sheffield
Puzey, Chauncey, F.R.C.S., Liverpool
Rand, J., F.R.C.S., Lordship Lane, S.E.
Randell, R. M. H., M.D., Beckenham
Ransford, T. D., F.R.C.S., Bath
Rawden, H. G., M.D., Liverpool
Rawlings, J. A., Swansea
Rawnsley, Surgeon-Capt. G. T., A.M.S.
Ray, E. Reynolds, Dulwich
Rendall, W., Maiden Newton
Reynolds, G. H., M.B., Hampstead
Reynolds, L. W., High Wycombe
Rigby, J. A., M.D., Preston
Riley, J. St. P., Salford
Rix, B., Tunbridge Wells
Roberts, H. W., Lewisham High Road
Roberts, R. J., M.B., Lowestoft
Robertson, J., M.D., Tulse Hill
Rodman, G. Hook, M.D., East Sheen
Russell, J. W., M.D., Birmingham
Rymer, J. F., Brighton
Sadler, H. G., Canterbury
Salter, C. E., M.D., Scarborough
Scott, T. G., Denmark Hill
Scott, W. J., M.B., Fenchurch Street
Sewill, J. Sefton, Cavendish Square, W.
Sheen, A. W., M.D., Cardiff
Shelswell, O. B., Mitcham
Shipman, G. W., Grantham
Simons, R. J., Gower
Smallpeice, W. G., Queen Anne's Gate, W.
Smyth, Sidney, F.R.C.S., Brockley
Spurrell, C., F.R.C.S., Bromley, E.
Starling, E. H., M.B., Tunbridge Wells
Steele-Perkins, G., M.B., Weymouth Street, W.
Stephens, Lockhart, Emsworth
Stephens, T. Palmer, Emsworth
Stephens, R. F., St. Austell
Stewart, F. G., Wadebridge
Stewart, H. M., M.B., Forest Hill, S.E.
Stokes, L., Lee
Strover, H. C., Sandy
Swayne, F. G., M.B., Upper Norwood
Swindlehurst, J. N., Peckham
Swinhoe, G. M., New Swindon
Sykes, J. F. J., M.D., Camden Square
Tanner, John, M.D., Cavendish Square
Taylor, A. S., M.D., Kingston-on-Thames
Thomas, J., F.R.C.S., Ty Cerrig
Thorpe, W. G., M.D., Clapham
Ticehurst, C. S., Petersfield
Todd, George, Torquay
Travers, O. R., St. Leonards-on-Sea
Tresidder, W. E., M.B., Nottingham
Turner, F. Charlwood, M.D., Finsbury Square
Turner, H. Gunton, Bournemouth
Turner, J. Sidney, Anerley
Veasey, H., F.R.C.S., Aspley Guise
Vernon, Claude N., Ashford
Wacher, S., F.R.C.S., Canterbury
Waddington, F., Leeds
Waddy, H. E., Gloucester
Walker, S., J.P., Middlesbrough
Wallace, R. T., Eltham
Wallace, R. U., M.B., Stamford Hill
Wallis, F. M., Bexhill
Walters, J. Hopkins, Reading
Warner, Percy, Woodford Green
Webber, H. W., M.D., Plymouth
Whitby, C. J., M.D., Limpley Stoke
Willan, G. T., Melton Mowbray
Williams, E., M.D., Clifton
Williams, R. E., M.B., Woolwich
Williams, W., M.B., Fishguard
Wilson, W., M.B., 184, Goldhawk Road, W.
Wise, W. C., M.D., Rushton
Wiseman, J. G., F.R.C.S., Ossett
Wohlmann, A. S., M.D., Bath
Woodhouse, A. E. C., Hanover Square
Woodruff, J. W., Reading
Wornum, G. P., Belsize Park
Worts, E., Colchester
Worts, S. E., Colchester
Worts, C. J., Fordham

It is earnestly hoped that replies will yet be received from all whose names are not to be found in the above list.

ARTHUR DURHAM MEMORIAL FUND.

BALANCE SHEET, DECEMBER 2nd, 1895.

Receipts.	£	s.	d.
To amount received to date	1850	10	0
" " " from various sources ...	253	19	6
	£2104	9	6

Expenditure.	£	s.	d.
By Cost of picture	60	0	0
" Printing and stationery	12	15	6
" Postage	4	16	6
" Advertising	5	17	6
" Clerks' time	21	0	0
" Cash invested	2000	0	0
	£2104	9	6

Audited and found correct,

L. A. DUNN.

Ed. H. LUSHINGTON,
Henry G. HOWSE,
P. H. PYE-SMITH,
} *Trustees.*

December 4th, 1895.

Hare-lip.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

Conclusion.

In double hare-lip various degrees of severity are met with. I will discuss the treatment of a severe case, one of those in which the middle of the upper lip appears to hang from the tip of the nose, and the premaxilla projects far in advance of the maxillary processes. In such a case I prefer to wait till the child is three months old. If possible, both sides should be operated on at once. I have several times divided the operation into two parts, joining one side first and then the other; but I find that the second operation is very difficult. The

premaxilla is apt to be tilted by the first operation, and the soft parts of the middle of the lip are so stiffened by inflammatory thickening that it is impossible to approximate the side of the cleft without much tension.

Many of the difficulties are the same as those encountered in single hare-lip. In addition you have to deal with the prominent premaxilla, and you will have much more trouble to secure a well-shaped nose. On both sides the cheek must be freely detached from the maxilla. On the left side the upper and lower flaps should be cut in exactly the same way as in single hare-lip, but on the right side the lower flap should be omitted. *All* the prolabium must be pared off the central portion of the lip, by an incision passing through three-fourths only of its thickness, and extending upwards upon the side of the septum nasi. If you attempt to utilize the central prolabium in forming part of the margin of the upper lip, you will find that the tip of the nose is drawn down and much deformity produced. The flaps should then be trimmed with scissors so as to make the raw surfaces on either side of the central part of the lip correspond in size to those upon the lateral portions, and to shape the upper flaps which are intended to form the floor of the nostrils.

The next point is to deal with the prominence of the premaxillary bone. An attempt may be made to push it forcibly back into its proper place. If this fails, the best plan is to make an incision through the mucous membrane which covers the posterior edge of the vomer at its lower part, and having laid bare both sides of the bone with a raspatory, to cut away a triangular piece with a strong pair of scissors. The premaxilla may then be readily pressed back into its normal relation with the maxillary portions of the alveolar process. I would advise you on no account to remove the premaxilla, for the removal of it not only involves the loss of important teeth, but entails considerable deformity from the falling back of the upper lip.

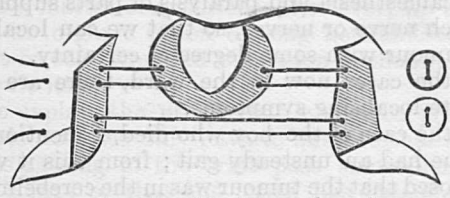


Diagram No. 4 will show the shape of the raw surfaces and how they are now brought together upon their deeper aspect by means of two pairs of button sutures. As in single hare-lip, the superficial adjustment is carried out by interrupted sutures of horsehair, and the same dressing and after-treatment should be employed.

Careful nursing is very important, so that the infant may be well supplied with properly prepared fluid nourishment, and may be kept as quiet as possible. Sometimes also there may be an occasional difficulty in breathing, from the closing up of the passage by which the infant has hitherto drawn in the air. The nurse should therefore be instructed to draw down the lower lip by gentle pressure upon the chin, whenever the infant appears to suffer any obstruction to respiration.

A Case of Hemianæsthesia.

CLINICAL LECTURE BY DR. TAYLOR.

THE Clinical wards being particularly rich in nervous cases, I propose to continue the subject of nervous diseases, which I have opened in my previous two lectures.

We have at present in the wards four cases which have been diagnosed as cases of cerebral tumour, and one such case died a few days ago. I have not time to deal in detail with all these cases, so that I will confine myself to *one* of them.

The case to which I want to draw your attention to-day, was admitted on August 30th this year, and went out about a week ago. She is a woman, aged 36, and came in for fits and headache. She is stated to have been always healthy; she had rheumatic fever when a child; she has been married for fifteen years, and has had several children, all of whom are healthy. Her husband says that she worries a good deal about her health.

Three years ago she began to have fits, which were not very severe. They were characterised by twitching of the face and some loss of power in the left leg. For the next eighteen months she continued to have fits; in these there was unconsciousness and twitching of the left angle of the mouth. In the summer of last year she was admitted to the South-Western Fever Hospital, at Stockwell, for diphtheria. During her stay in that hospital she had a fit followed by hemiplegia on the left side, the paralysis gradually clearing up. Since that time she has had ten or twelve fits coming on with menstrual periods. She did not bite her tongue in any of the fits. The attacks were preceded by giddiness and headache, but no definite *aura*. During

the attacks she had left-sided convulsions. She also often vomited, but the vomiting had no relation to food.

Whilst at Stockwell, the patient had ptosis for some time. The onset of the epileptiform seizure she had there was sudden, and it was followed by hemianæsthesia and paresis on the left side. She improved gradually, but had considerable loss of power in the left leg when she went out.

On admission to this Hospital the temperature was normal; but the respirations and pulse were rather rapid, the former being 30 and the latter 94. When the patient was brought to the surgery she was comatose. The conjunctival reflex was absent, her pulse was feeble, and her extremities cold. In the ward she gradually recovered consciousness. After the attack she was quite intelligent and spoke quite clearly. She had a limited field of vision on the left side; she also had diplopia or double vision with the left eye alone. Tactile sensation was deficient. The left arm and the left lower extremity were weaker than those of the other side. The grasp of the left hand, measured with the dynamometer, was seventeen pounds, and that of the right forty pounds. She had a severe headache, which was chiefly frontal. Below the ankle there was complete anæsthesia, and sensation was defective to the left of the middle line right up to the head. The wrist and elbow jerks were present on both sides, and there was no clonus. A systolic murmur was heard at the apex, and could be traced outwards to the axilla. This was no doubt connected with the rheumatic fever which she had during her childhood. Her tongue was dry; she had a bad appetite, and her bowels were very constipated.

Since then the symptoms in the main have remained the same. The paresis and anæsthesia of the left side persisted, though it varied somewhat. Her eye-sight remained the same. She also continued to suffer a good deal from sickness and headache.

A great many remedies were tried during her stay in the Hospital. She had potassium iodide, potassium bromide, tinctura opii, morphia, sulphonal, trional, and cannabis indica; besides aperients such as croton oil, senna, etc.

Now, as to the cause of these symptoms: The first view entertained was that it was due to a tumour of the brain. Let us consider it first from that point of view. There is a very general resemblance between the other four cases of cerebral tumours which we have, or have had, in the wards. In all there are the characteristic conditions that obtain in a typical case; these are:—

1. *Headache* of varying severity. Some have very severe headache, the others comparatively slight.
2. *Sickness* also of varying severity.
3. *Double optic neuritis.*

The patient who died was a child five years of age, and death occurred in a very interesting way after an illness of four weeks' duration. He had the above symptoms, sickness, headache, optic neuritis, and also an unsteady gait. The respirations became very rapid, and were accompanied by stertorous breathing. The case quickly ended fatally, the pulse continuing for some time after respiration ceased. The failure of the respiratory functions before those of the heart has been often noticed in cases of tumours of the brain.

Two of the cases now in the ward are walking about; the other stays in bed, suffering from a very severe headache.

You all, no doubt, know these symptoms of cerebral tumour, as I lectured on a case in the spring of this year. In regard to cerebral tumours it has always been laid down that the three symptoms already mentioned are very constant. Another symptom may be sometimes present, viz., convulsions; but this is not nearly so constant as the other three.

These three symptoms only indicate that there is increased intracranial pressure, nothing as to the position or nature of the tumour can be inferred from them. The only thing that we can say is that if the symptoms are of long duration, they are probably caused by a tumour.

If you add convulsions to the other symptoms, you may be able to say something further about the tumour. Certain kinds of convulsions only indicate increase of intracranial pressure, like the above symptoms. Other kinds of convulsions indicate approximately the site of the tumour, and from others again you can say the exact spot where the tumour is. If the tumour is at the base of the brain it will involve or press on one or more of the cranial nerves, and cause anæsthesia and paralysis of parts supplied by such nerve or nerves, so that we can localise the tumour with some degree of certainty.

In the cases now in the ward, there are no definite localising symptoms.

In the case of the boy who died, I mentioned that he had an unsteady gait; from this it was diagnosed that the tumour was in the cerebellum, which, after death, was found to be the case.

Now to go back to the case of the woman, and see how she stands with regard to these

symptoms. We find that she has two out of the three, viz., sickness and headache. She has no optic neuritis, and in order to be quite certain of this, Dr. Brailey was asked to examine her, and he said that there was no optic neuritis; neither has she any optic atrophy, a condition which is generally preceded and caused by neuritis. This is a very interesting and may be a very important fact, because optic neuritis is so constant in cases of cerebral tumour; and still more remarkable in that the history of the case is a very long one—namely, about three years.

The other cases—though they only date, one from June, another from Easter, and the third from July of this year—have all of them double optic neuritis as a result of intracranial pressure.

The little boy who died had marked double optic neuritis, though he only lived for a few weeks after the commencement of the attack.

Now with regard to her convulsions. At times she has been affected with convulsions, sometimes of the left side of the face and at others of the left limbs. From this we should infer that the lesion must be on the right side of the brain, involving the motor centres or tract. Voluntary motion and sensation are also affected on the left side, thus pointing to a lesion on the right side of the brain. Further, with regard to the exact position of the lesion, we know that, to produce hemiplegia, either (1) the lesion must be in some part of the motor tract in the brain—*i.e.*, in the fibres converging from the cortex to the internal capsule, or in the internal capsule itself, or some part of the tract between this and the upper part of the bulb; or (2) it must be in a position to interfere with one of these parts by its pressure. We also know that the motor tract in the internal capsule occupies the anterior two-thirds of the posterior limb between the optic thalamus and the lenticular nucleus, and the sensory fibres occupy the posterior one-third of this posterior limb. These sensory fibres are probably continued upwards towards the cortex in very much the same direction as the motor fibres, so that we may easily imagine that both kinds of fibres may be implicated here.

As a matter of experience, however, we know that an organic lesion causing hemianæsthesia must be somewhere in the region of the internal capsule itself.

To explain the ptosis that was once present in this case, we only have to imagine that some fibres passing to the orbit pass somewhere at this point; or that the lesion has extended in some direction so as to implicate these fibres.

Having thus taken the points that are in favour of an organic lesion, let us see whether it might be something else. You may ask, why should there be any suspicion in this case? It is because experience of many years shows that a large proportion of cases of hemianæsthesia are functional in their nature. That they may result from an organic lesion of the brain is quite true, still it is not very common.

In medical diagnosis, and in other diagnoses too, one is to a certain extent guided by our knowledge of what things are most common; and we must never neglect the consideration of those possibilities in a case, which are most frequently realised.

Accordingly, I will now take the points which are in favour of this case being functional, so that we may balance them against the points that have already been considered as indicating an organic lesion.

The first point of interest is that there is a very long history, viz., two or three years, whereas most cases of cerebral tumours are terminated in a much shorter time. Still, some cases do last for a long time; for example, the case I lectured upon to you in the spring of this year had lasted from May, 1894, up to that time, and still lives through an illness of eighteen months,* so that we must not put too much stress on the duration of the lesion.

Another point is that this patient is improving a good deal now; and has varied much from time to time. But in this connection it must not be forgotten that some cases of cerebral tumour seem to get well, and do at any rate live. I remember the case of a boy who had a very severe headache, great enlargement of the head from ventricular distension, staggering gait, and double optic neuritis. I saw the boy seven years afterwards, when the symptoms of the tumour had disappeared, except that the boy had become quite blind, and his head remained disproportionately large.

Two years ago a girl, æt. 12, came in with typhoid fever. We found that she had been in the Hospital three or four years before with typical symptoms of cerebral tumour. She was still blind from double optic atrophy. Though these two patients have lived they are still permanently damaged as regards their eyes. Our present patient has no such condition.

Then with regard to the convulsions and fits. These seem to indicate an organic lesion so far as one can tell. She had convulsions affecting the lower part of the face, the left arm, and the left lower extremity. She remained unconscious for some time, in one case for several days, and she

* He died shortly after this lecture was delivered.

only gradually recovered from the paralysis. There seems to have been no doubt in the minds of those who saw them that they were genuine fits. We cannot say anything positively about these: she, however, had one fit while in the Hospital which is thus described in the report:—"On September 16th patient had a fit, but she did not become unconscious, and was complaining, all the time that the fit lasted, of sensations of pins and needles in her extremities on both sides. The angle of the mouth on the left side was depressed. Respirations became very rapid, varying from 50 to 70 per minute. The attack was sudden in its onset, and disappeared quite as suddenly." From this description one cannot but entertain a strong suspicion, and even more than a suspicion, that the fit was hysterical.

Next, as to her strength of grasp. It is stated in the report that the grasp of the left hand was seventeen pounds, and that of the right was forty pounds; she may have not been able to grasp more with her left hand, but she was certainly not putting all her power into the right hand, because she was not at all a weak-looking woman, and the ordinary power of grasp varies from 80 to 120 pounds.

To test better the loss of power in the left leg, we got her out of bed. At first she could not walk, but we induced her to walk at last. The way she walked was very characteristic of hysterical patients; she stepped forward with the right foot, and then dragged the left foot forward until it was exactly opposite the right, and then stepped forward with the right again. If this was due to a cerebral lesion, all I can say is, that it was exactly like what happens in hysterical patients. We allowed her to get up every day after this, and with a little pressure we were able to get her to bring her left leg in front of the right, and she improved considerably in her walking. This improvement very strongly points to a functional origin of the trouble.

Associated with the complete left hemianæsthesia, she has diminution of the field of the vision on the left side, loss of the sensation of smell, and loss of taste on the same side; this is what one has constantly in hysteria, but it also occurs when hemianæsthesia has an organic cause.

The field of vision was narrowed down to a small circle about quarter of an inch in diameter round the central point of the chart. The report says that during the examination of the right eye the patient became hysterical, so that no more satisfactory chart could be taken.

Another point of great interest is that the anæsthesia is complete, whereas the paralysis is only partial and varies very much. I do not remember to have seen a case where this has occurred in an organic lesion of the brain. Again, the loss of power in the leg is much more marked than in the arm. This is contrary to what happens as a result of organic lesions of the brain affecting the motor tract, the arm being always more affected than the leg in these cases. Separate lesions of the respective motor centres might previously do this.

She also has monocular diplopia—*i.e.*, she says she can see double with the left eye when the right is closed. This has often occurred in hysterical cases, but has been seen in people with cerebral and other lesions.

The explanations given of the phenomena are (1) that there is some irregularity of the lens which causes two images to be seen, or (2) that there is a spasm of the ciliary muscle. The cerebral cases in which it happens are those of mental disturbance, and also in cases of tumour. I remember seeing a case of it in a man who suffered from locomotor ataxy. The man stated that within a distance of eight to ten feet from him everything appeared double, with either eye, the other being closed. Beyond this distance he saw everything quite clearly.

I think that I have now drawn attention to most of the points suggestive of hysterical associations in this case.

From what I have said as to the variability of the symptoms indicating a functional origin, you must not think that all organic cases go on uniformly. In most cases the symptoms vary from time to time, especially the sickness. But there is not much variability in the paralysis. Either the tumour must go on increasing in size, or attain a maximum and then remain stationary or retrogress. I cannot conceive of a tumour increasing in size for a time, then receding for an interval, and afterwards repeat this increase and retrogression almost indefinitely.

I shall now say a few words about the localising value of pain. Here the pain is said to be frontal. There is no doubt that in cases of meningitis the pain is often over the part of the skull corresponding to the lesion; but in lesions of the brain itself the situation of the pain varies a good deal. It is true that it often happens that patients with cerebellar tumour have pain in the occipital region, and people with disease in frontal lobe have pain over the forehead, etc., but there are many exceptions, such as the following:

The boy whom I have already alluded to, who died of cerebellar tumour, had frontal headache.

In a girl who was admitted in September, having suffered for six weeks from headache, sickness and double optic neuritis, the pain varied from time to time, and was not definitely localised.

Another patient had pain in the temples and forehead; and the patient who is up in Stephen ward suffering probably from cerebellar tumour, has pain both in the forehead and in the back of the head.

Finally, with regard to our own case, I cannot so far provide you with a confirmation of my views with regard to her. A few days after the application of electricity, which was ordered for her, she preferred to leave the Hospital, and I regret that we did not induce her to stay to submit herself to the continued treatment for hysteria, which is sometimes almost as difficult to cure as tumour itself.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	2, 7.	Chlorosis.
	3.	Mitral regurgitation.
	12.	Communication between pulmonary artery and aorta. Aortic and mitral regurgitation. Ascites.
	16.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	17.	Ulcerative endocarditis.
	18.	Mitral stenosis and regurgitation.
	28.	Thoracic aneurysm.
	29.	Exophthalmic goître.
	35.	Mitral stenosis and regurgitation.
	36.	Mitral stenosis.
	50.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
Stephen	4.	Mitral regurgitation.
	21.	Aortic stenosis and regurgitation.
	34.	Mitral regurgitation. Adherent pericardium.
Philip	6.	Dilated heart.
	9.	Aortic stenosis and regurgitation.
	10.	Aortic regurgitation. Hypertrophied heart. Albuminuria.
	30.	Aortic stenosis and regurgitation.

Nervous System.

Mary	8.	Locomotor ataxy.
	9.	? Meningitis.
	30, 32.	Chorea.
	49.	Paralysis agitans.
	Cot 56.	Muscular atrophy.
Stephen	2, 22.	Right hemiplegia.
	18.	Paraplegia. Chronic myelitis.
	23.	Ataxy. ? Cause.
	36.	Locomotor ataxy. Perforating ulcer.
	39.	Chorea.
Philip	20.	Locomotor ataxy.
	23.	Hæmatemesis. Gastric ulcer.
	26.	Epileptiform convulsions.

Alimentary System and Abdomen.

Mary	4, 11, 23.	Gastric ulcer.
	24.	Abdominal tumour.
	27.	Jaundice. Enlarged liver. ? Carcinoma.
	33, 39.	Appendicitis.
	48.	Pelvic peritonitis.
Stephen	1.	Gastric ulcer.
	10.	Ascites. Cirrhosis of liver.
	12.	Gastro-jejunostomy for pyloric obstruction.
	13.	Epithelioma of œsophagus.
	16.	Appendicitis.
	26.	Tubercular peritonitis.
	33.	Enlarged spleen. Œdema of back and legs. ? Cause.
Philip	16.	Abdominal abscess.
	17, 27.	Ascites. Cirrhosis of liver.
	31.	Appendicitis.
	34.	Carcinoma of stomach.

Typhoid Fever.

Mary	? 9, 14, 21, 26, 37, 38, 47.	
Stephen	32.	

Genito-Urinary System.

Mary	6.	Tubal nephritis.
	20.	Chronic nephritis. Gout. Hypertrophied heart.
	42.	Chronic nephritis. Hypertrophied heart Aortic regurgitation.
	46.	Chronic nephritis. Left hemiplegia. Mitral stenosis.
Stephen	6.	Tubal nephritis.
	8.	Chronic nephritis. Gout. Hypertrophied heart.
	22.	Chronic nephritis. Right hemiplegia and aphasia.
	31.	Chronic tubal nephritis (white spot surrounded by black pigment in retina, below and internal to the left disc).
	38.	Tubal nephritis.
Philip	13.	Chronic nephritis. Hypertrophied heart.
	14.	Diabetes mellitus.
	18.	Chronic tubal nephritis.

Respiratory System.

Mary	25.	Pleurisy, etc.
	41.	Phthisis.

Stephen	28. Phthisis.
Philip.	3, 24, Pleurisy with effusion.
	36. *Hæmoptysis.*

Miscellaneous.

Mary	1. Uterine fibroids.
	10, 22. Osteo-arthritis.
Stephen	7. Lymphadenoma.
	20. Congenital syphilis. Albuminuria. Enlarged spleen.
Philip	29. Lymphadenoma. Mediastinal growth.

Acute Rheumatism.

Mary	15.
Stephen	29, 37.
Philip	1, 7, 15.

Case under Dr. Washbourn.

Cerebral Abscess.

Mary 11.—E. M., æt. 48. Admitted late in the night of October 16th, in a semi-comatose condition.

History.—Patient could not answer questions sensibly, but a friend who came up with her stated that she had had several attacks of rheumatic fever; and added that she was an habitual drunkard, and had lately been drinking freely. It was discovered later that her daughter, a girl of eighteen, had been in Mary, under Dr. Pye-Smith, in 1890, and that she had had a cerebral abscess, which had been operated upon by Mr. Jacobson, and that she had recovered.

Present illness.—Patient had staggered in walking for three or four weeks, but was fairly well till October 9th, a week before admission. She then complained of severe pain in left temporal and frontal regions, which lasted two or three days, but was relieved by mustard plasters. On October 13th she was bright and cheerful and ate a good dinner, but towards evening became light-headed.

On admission.—Patient was a stout, flabby-looking woman of 48. She could speak, but could not answer questions intelligibly and wandered in the replies. Temperature was subnormal; respiration 32; pulse full and slow. The tongue was furred; the breath very foul. The left membrana tympani was perforated, and there was a foul-smelling discharge from the left ear. The lungs were normal. The knee-jerks were brisk. There was slight ptosis of left eyelid (but this was said to have been always present). To the inner side of each optic disc was a whitish patch, but this was a chronic condition, and there was no optic neuritis.

September 17th.—Patient more comatose, but still able to speak; passed her urine in the bed. Towards evening she became more comatose, and the breathing was louder and a little stertorous. Urine was drawn off by catheter, sp. gr. 1026; contained albumin. The left pupil was dilated, the right remaining the same size as before. The knee-jerks could not now be obtained. The temperature rose to 100° at night. Pulse still slow.

18th.—Patient comatose and could not be roused; breathing stertorous. Both pupils were dilated. The breathing became more stertorous, and the temperature rose to 101·2°, after being 100·6° in the morning. It was decided to explore the mastoid cells. No anæsthetic was needed. Patient stopped breathing during the operation, but recommenced with artificial aid. The breathing again stopped, and she died before the trephining could be completed.

Post-mortem.—Otitis media. Abscess, 1½ by 1¼ inch, in left temporo-sphenoidal lobe, involving third temporo-sphenoidal convolution on its outer and under surface. The abscess was in the brain-substance, and where it touched the dura mater there were some granulations round a spot where the dura mater had sloughed and a small extra-dural abscess. The lateral ventricles were large and contained blood-stained fluid.

Comments.—When patient was admitted it was at first thought that her condition might be due to alcoholism, as the history pointed in this direction, and as the ptosis, which was said to have been always present, and the discharge from the ear, the duration of which could not be ascertained, were the only indications of a cerebral cause. On the 17th the presence of albumin suggested the possibility of uræmic coma.

After the patient's death it was stated that the discharge from the ear had begun four days before admission, and doubt was thrown on the history of alcoholism.

Both in her case and in that of her daughter (referred to in the history), the abscess was situated in the common position—the temporo-sphenoidal lobe. An abscess in this position may press upon the lower motor centres and produce paralysis of the face and arm; more commonly it produces no localising symptoms.

In the Out-Patients' Department.

Two Cases under Mr. Lane.

Talipes Varus.

Two children, aged respectively two and three months; both feet of each in varying degrees of adduction and extension. Mr. Lane pointed out that there are two forms of congenital deformity of the feet, both of which were retentions of positions that were normal at one period of intrauterine life. They are, talipes varus and talipes calcaneus. At one time he thought that the varus variety was the more common, and this is the general teaching. Now he inclines to the belief that the calcaneus variety is probably nearly, if not quite, as frequently met with as the other: it does not, however, come under the observation of the operator very often, for this reason, that it is often very transient, lasting for only a short period after birth, and in the large proportion of cases disappearing spontaneously. He strongly condemned the practice, common amongst medical men, of postponing interference with the varus variety till an interval of one, two or more months had elapsed from birth. In this manner very valuable time is lost, which

can never be compensated for by subsequent treatment. For instance, the younger of these patients was seen for the first time, and the elder was said to have been brought to a hospital when a month old by direction of the medical man, and to have then been told that nothing could be done till the child was three months old. Mr. Lane advised manipulation in the very frequent application of plaster of Paris bandages put on with the greatest skill and care; this treatment should commence from birth. He had seen the most satisfactory results derived from this early treatment, and (too often unsatisfactory) operative measures avoided. Of course it was obvious that the result obtained must vary enormously with the circumstances in which the child is placed.

A very considerable hypertrophy of the eye-lids on both sides in a girl aged twenty presented points of much interest. The lids projected as large swollen masses, about as large as walnuts, rendering it very difficult for the patient to separate their edges for more than a very slight distance.

This condition had resulted from frequent attacks of erysipelas of the face, which commenced about two years ago. After the earlier attacks, the lids resumed almost, if not quite, their normal condition, but as time went on the gradually-increasing masses remained.

Mr. Lane said that these cases had been described by Mr. Hutchinson, who had excised portions of the thickened tissues and found them to contain a considerable quantity of fibrous tissue and dilated lymphatic channels. He considered it very likely that the erysipelas micro-organisms were lying in a latent state in the thickened lids, and started into activity when the vitality of the individual was depreciated locally or generally.

He had obtained great and permanent benefit in such cases by electrolysis. The treatment usually adopted is to excise portions of the lids, but this he considered unsatisfactory and much inferior to electrolysis.

Some points connected with the Radical Cure of Hernia.

By W. H. A. JACOBSON, M.Ch.

The following points claim attention, and while the improvements of modern surgery have established radical cure on a sound scientific basis, many questions remain still undecided. The chief of these are:—(1) The justifiability of the operation. (2) The use of the terms, "radical cure" and "permanency of the cure." (3) The earliest age at which the operation is advisable in children. (4) The advisability or need of wearing a truss afterwards. (5) The best material for suture. (6) The best form of operation.

(1). *The justifiability of the operation.*—Before we can answer this in the affirmative we must be able to honestly feel that the operation is safe, (*a*) *as regards the patient's life*, (*b*) *as regards the testicle.* Only those surgeons who have had experience in operating, who are thoroughly acquainted with the needs of Modern Surgery, and who will pay the needful attention to every detail can promise the above safety.

(*a*) *The safety of the patient's life.*—The following recent statistics show what modern surgery and experienced hands can do. Professor Macewen has operated on 104 cases of radical cure for oblique inguinal hernia with only two deaths, both in children, one from scarlet fever, the other from measles and meningitis. Dr. Coley, of New York (*Ann. of Surg.*, April, 1895, p. 391), has operated on 160 cases of inguinal hernia by the Bassini method with only one death, due to a double pneumonia, on the eighth day. And did space allow, many other excellent results might be given. (*b*) *The safety of the testicle.*

(2). *The value of the term "Radical Cure," and the permanence of the cure after operation.*—Present results give the promise of great improvement here. A few years ago some of the best authorities here were not using the term radical. Thus, Mr. M. Banks, one of the earliest and foremost workers on the subject, and a writer who has given his results with honest frankness, considered the term "radical cure" misleading. "It is popularly understood that a patient upon whom the radical cure has been performed need never again wear a truss, nor ever again be in danger of his hernia coming down. This is, unfortunately, far from being the case. The instances in which a light truss can be dispensed with are in the minority." A few years later (*Brit. Med. Journ.*, 1893, vol. ii., p. 1044), Mr. Banks wrote somewhat more hopefully. Of 168 cases, he had traced for very considerable periods 113; of these 79 remain quite sound, 19 are partial successes, and 15 are complete failures. In America—where, as with oophorectomy and removal of the appendix, this operation has been resorted to more freely than in this country—warnings have been given by some of the best-known surgeons that the use of the term radical cure may be premature. Amongst the chief of these has been Dr. W. T. Bull,† Surgeon to the Hospital for the Ruptured and Crippled of New York. Dr. Bull has collected 137 cases operated on for radical cure in which a relapse has taken place, and he adds that these relapsed cases "probably represent but a small proportion of those operated on."

Mr. Macready, Surgeon to the City of London Truss Society, writes the following weighty words on what he calls the unsatisfactory nature of the evidence as to efficacy of the radical cure (*A Treatise on Ruptures*, p. 234): "The evidence brought forward by one surgeon after another in favour of these operations is always of the same character. A number of cases are given in which the operation has been performed, and in which the result has been watched for periods varying usually

* Pamphlet, *Med. Times and Gaz.*, 1884; *Brit. Med. Journ.*, Dec. 10, 1887.

† *N. Y. Med. Journ.*, May 30, 1891; *Med. News*, 1890; *Annals of Surgery*, 1893, vol. i., p. 534, *et seq.*

from a few months to four or five years. Very few cases are under observation so long as five years; for the patient changes his residence or declines to show himself. M. Terrier on one occasion wrote to twenty-five old patients, and received only two replies. It must not be supposed that a patient is cured because he does not come for inspection. The relapsed cases at the Truss Society have almost all been asked if they have visited the operator to show him the result. In the great majority of cases they prefer not to go back, and very often, alas, express themselves as if a deception had been practised upon them. It is much to be regretted that patients should feel this reluctance to face the operator again, for in consequence the surgeon is apt to form too favourable an opinion of the efficacy of his plan. Sometimes a patient after remaining cured for a number of years passes from under observation and again becomes ruptured. . . . All that we can say of the operations, involving complete removal of the sac, is that they all give immunity to a certain number for a certain time."

While opinions like the above, candidly expressed by surgeons of wide experience, will carry special weight with all thoughtful surgeons, it is probable that the work of the last few years, and still more that of the coming decade, will place the radical cure of hernia on a firmer and more satisfactory basis.

We are now learning more distinctly the principles on which this operation is to be conducted. Two or three methods have now been employed on such a large scale, and with such excellent results, that it seems probable that a permanent cure can be promised in a large number of favourable cases. This qualified statement requires explanation. By a "permanent cure," I mean a cure which will last a lifetime. By "favourable cases," I mean children, young subjects, herniæ of moderate size, where the rings and canal are still present and not stretched and converted into one large direct gap into which the tips of two or three fingers can be easily placed; cases where the patients operated on have sense enough to give the newly-repaired structures sufficient rest for their consolidation, and where, if they must follow employment or exercise that involve much straining, they will give the parts the support of a truss of light pressure or a belt* *(vide infra)*. If this is not done we shall see, if cases are carefully followed up and candidly reported, that radical cures will not last a lifetime, and that the term will have to be largely replaced by the following, according to the degree of cure obtained—viz., "complete successes," "partial successes," "complete failures."

For cases to be reported as really successful it will be needful to follow them up for a much longer period than has hitherto been the case. In studying such lists as those published by Coley (*loc. supra cit.*), in which it is claimed that of the 160 cases of inguinal hernia operated on by Bassini's method, with kangaroo tendon for a buried suture, not a single relapse occurred; in a very large proportion of the cases the "final result, perfectly sound," is recorded within six months of the operation. Such results, while proving the safety of the operation for the life of the patient and encouraging for the future, are not to be taken as proving that a really radical cure can be secured by the method given. It is to be feared that such reporting of cases may be actually misleading by causing much less competent operators to think lightly of the operation, and to be over-sanguine in promising results.

It is noteworthy that with regard to this premature publication of results that cases of very late relapse have been noticed when the patient has been left long under observation. Thus, one occurring at a period of four and a half years is noticed by Dr. Bull (*Ann. of Surg., loc. supra cit.*, p. 535). Here the case had been operated on by Dr. Weir by Macewen's method. Here Dr. Weir's name and the time that had elapsed between the operation and the recurrence are sufficient guarantees that the operation had been properly done. In another case eight years had elapsed.

From the above it is clear that when consulted as to the performance of a radical cure by patients the subjects of hernia, they can be assured as to the safety of the operation and the probable permanence of the cure in favourable cases (*vide supra*). Furthermore, it is certain that if a relapse should recur the majority of patients will be better off than before the operation. The protrusion that appears will be smaller than the original rupture, more readily kept within bounds, like a bubonocele, and a truss will be worn with greater comfort. On the other hand, if suppuration occur, and a thin-walled feeble cicatrix, sure to yield increasingly as years go on, is the only result, the outcome of the operation may leave the patient worse off than he was before.

(3). A question that often arises relates to *the wearing of a truss and the possibility of the hernia being cured by this means alone.*

The answer, deciding between the wearing of a truss and an operation for radical cure, will depend greatly on the mind of the surgeon consulted. If he is one of those (I confess I am of the number) who believe that this operation is too indiscriminately resorted to, he will hold that no operation, save for special reasons (*vide* Indications for Operation), is to be advised where the hernia can be kept up by a truss; that a light and well-fitting truss is not the bugbear it is too often made out to be by those who advocate operation as the rule. It would be well if surgeons would spend some of that pains and trouble in ensuring that the truss fits, before it is thrown aside, which they give to inventing or modifying operations for radical cure, and if patients would exert a little more trouble and pains in getting a proper and well-fitting truss at a duly qualified instrument-maker's, instead of the first cheap trash which they see in a chemist's shop. I have pointed out below, under the

* Many will say that if any truss or support is worn after, the cure is not *radical*. I admit this, but reply, that until published series of cases have been watched for a much longer period, we shall, as relapses may occur five or eight years after operation, do wisely to advise our patients to support the restored region with a well-fitting truss of light pressure, and so bring about a permanent cure instead of a liability to relapse.

heading Indications for Operation, the cases where this question of wearing a truss does not arise.*

When this question, whether the wearing of a truss will effect a radical cure, arises in the case of infants and children, these cases may be divided into the following groups. In one, and this is the largest of the three, the careful wearing of a truss by a child will permanently cure the rupture. In a second group—a large one—the hernia, though not cured, will be perfectly controlled with very slight inconvenience to the patient. In the third—a very small one—there is no tendency to spontaneous cure, even when a suitable truss has been diligently worn.

On this follows naturally the next question: *What is the earliest stage at which an operation should be performed?* Below I have stated my opinion, that while it is occasionally justifiable to operate in the second year of life, where a persisting hernia is large, it is, as a rule, better to defer operation till the age of four, or later.

(4). *The advisability or need of wearing a truss afterwards.*—The tendency of the present day to condemn offhand or to deprecate strongly the use of a truss after an operation for radical cure is, I think, a great mistake. Each case must be judged separately. With regard to children, from an experience of my cases, I think that if the recumbent position be insisted on for three months after the operation, so as to give the newly-restored parts time to consolidate firmly, a truss will not be subsequently required, so great is the tendency to repair in early life. Umbilical herniæ I am inclined to make an exception: the communication which has here been closed has been relatively so large, the stress thrown upon it after repair in expiratory efforts (as when the child cries every time at the approach of the surgeon or dresser during the after-treatment), is so direct, that the scar should, I think, have support for some time in the form of a well-fitting belt.†

In adults, the objection usually made to a truss is that its pressure will produce absorption of the scar. While it will be granted at once that any continuous pressure in the form of a pad with a strong spring will tend to weaken and remove the inflammatory thickening resulting from the operation, I am distinctly of opinion that some well-fitting slight support in the form of a truss or belt should be worn in the following cases—viz., where the abdominal walls are very fat, flabby and pendulous; where there is heavy work, either done continuously or by fits and starts; where any silk has worked out, or where the wound has healed by suppuration; in some cases, where the radical cure has been done after an operation for the relief of strangulation, and the surgeon has perhaps been hurried, or has operated at night, and, of course, in cases where there is any return of the hernia. Other cases are umbilical herniæ, both in adults and children, for the reason I have given above; in femoral herniæ, owing to the difficulty, in many cases, in doing more than twisting, tying or inverting the sac, and also because the sex and dress of the patient usually makes the wearing of a truss less irksome. On the other hand, in early congenital cases, in boys, in young adults without laborious work, or where the reparative power is good, where sufficient rest has been taken after the operation, and where primary union has been secured and remains firm, no truss need be worn. But the importance of intelligent supervision at intervals should be insisted upon.

The presence of a cough, carelessness about constipation or a stricture will, of course, be duly weighed; and I may remind my readers of a warning uttered above, that relapse may take place as late as four or even eight years after a skilfully performed operation.

The best form of Suture.—Though hitherto I have used silk, I am of opinion that kangaroo tendon, if a suitable specimen, duly sterilized, can be obtained, will be found preferable, and I intend to make trial of this in future. Silk is most satisfactory to work with at the time; it can be obtained at once, it is soon sterilized, it is strong, and it lends itself readily to easy tying and a secure knot. But the after result is, in my opinion, less satisfactory, owing to its tendency to come away, often persistently. There is a tendency to believe and teach that wherever silk comes away after an operation, it must always be due to some deficient sterilization of the silk, or to some failure to keep the wound aseptic. While these are leading causes, they are not, I am persuaded, the only ones; the site and the character of the tissues concerned play a very important part. Inside the peritonæal cavity, where the ligature lies deep and is surrounded by a serous membrane, as with an ovarian pedicle, we are certain our silk ligature will give no trouble; in ligature of the carotid or femoral artery, where the ligature also lies deep and is surrounded by vascular structures, we rarely have trouble with our silk ligatures; but here, where any silk used lies comparatively superficially and embedded in fibrous tissues, such as the conjoined tendon or Poupart's ligament, its surroundings are so different that a surgeon need not always blame himself for deficient asepsis, nor faulty tying when his silk comes away. I am aware that many surgeons, higher authorities than myself, claim that silk, wire and salmon-gut can all be used as buried sutures without any further trouble. In a certain and large proportion I know from experience that silk can be used, but in a considerable number this and the other materials most certainly cause trouble later on. The wound runs an aseptic course, heals without suppuration, and then, after a varying period, a sinus appears, and one or more of the sutures have to be removed. Professor Macewen uses chromicised catgut, prepared by himself. Dr. Coley, in the paper referred to previously, used kangaroo tendon in 160 cases, and though the interval between the date of operation and that of publication is in very many of them far too brief for the cure to deserve, in my opinion, the term radical, the constancy with which primary union was secured speaks very strongly, I think, for the use of kangaroo tendon in

* An ill-fitting truss is, of course, worse than useless, and may mat together the tissues.

† Any phimosis or cough should be of course treated.

preference to silk, and I intend to give the former material a trial.*

Indications.—The following are given only as types of appropriate cases. Many others will suggest themselves:—

(i.) Cases of irreducible hernia where other treatment has failed, where an active life is interfered with, or where attacks of inflammation have occurred, or strangulation threatened. Subjects of inguinal hernia with adherent omentum are never really safe, especially if of active life; from this, however, they are usually debarred. Femoral hernia containing irreducible omentum should also be operated on. These herniæ are difficult to fit with trusses; the omentum keeps the ring open, and thus paves the way for the descent of bowel on any sudden exertion. Where irreducible herniæ are small, and the adhesions easily separated, very great relief will be given the patient with very slight risk. But it is otherwise where the sac is very large, or the contents very adherent, especially about the neck of the sac. In either case the risk of peritonitis is considerable; in the one case, from the direct opening into the peritonæal cavity which may be present, the large amount of contents which have to be manipulated, and the difficulty of keeping the operation extra-peritonæal. Again, intricate adhesions about the neck of the sac may either lead the surgeon to abandon the operation, or to lay open the abdominal wall in order to deal with them. The last step not only increases the risk of peritonitis at the time, but may bring about, some time later, a hernia very difficult to control, the ultimate improvement in the patient's condition being thus of a very limited nature.

(ii.) Cases of strangulated hernia where the patient's condition admits of the operation being prolonged.

(iii.) Cases where a hernia is not controlled by a truss, but slips beneath it. Such cases should be extremely rare if patient and surgeon alike showed sufficient pains and patience in securing a well-fitting truss.

(iv.) Cases of hernia with ectopia testis where the fitting of a truss to keep the hernia up and the testicle down fails. Castration should always be performed when the condition of the testis is useless or doubtful.

(v.) Cases where the hernia can be controlled by a truss; but the use of this is irksome to a patient of very active life, where he wishes to join the army or navy, or where he may, as a colonist, be far removed from surgical help.

(vi.) Children of poor, ignorant and incompetent parents, with large herniæ, where proper attention to the use of a truss cannot be secured, or where the persevering use of this has failed, and where all such causes as phimosis, cough, etc., have been removed. It will probably be justifiable to go further than this, and to operate for radical cure in most cases of herniæ in the children of the poor in which the hernia is still large at four to six years of age.† By this time the parts are better developed and more easily kept sweet. The sac is more easily dealt with now than later. The presence of any conditions which call for exploration—viz., hydrocele, adherent omentum, the presence of the appendix, will also be indications for operation in children.* On this point operation for radical cure in little children I will quote Mr. Macready *(loc. supra cit.*, p. 256). We may all envy his especial experience and strive to imitate his skill. "Uncontrollable ruptures in children under fifteen are very rare; to me, indeed, they are as yet unknown. I hope it does not imply any lack of charity to say that one can measure with fair accuracy a surgeon's skill in the management of trusses by the number of curative operations he performs on children."

(vii.) Large herniæ, even colossal, where the patients, unfitted for work of any kind, are a burden to themselves and others,† and perhaps willing to run great risks; for it cannot be denied that these are very grave cases: "The operation usually difficult and prolonged, and the dangers to be met and overcome both numerous and various" (Banks). The chief of these is the direct and gaping communication with the peritonæal cavity and the difficulty in keeping the operation extra-peritonæal. The best proof of this is given by Mr. Banks's series of sixteen very large and enormous herniæ; of these he lost four, two from septicæmia. In another, even his hands failed to complete the operation.

(viii.) I consider ten to twenty-five years of age as the most favourable time, as combining parts easy to handle, the possibility of keeping the wound aseptic, probable absence of any difficult adhesions, and good vitality and health.

* Whatever material be employed it must be sterilized by the surgeon himself, and not left, haphazard, to others.

† This age is mentioned above as giving time for trials with a truss

* Before deciding that a well made truss will not keep up a difficult case—*e.g.*, a double inguinal hernia—the hernia should be completely reduced with the aid of an anæsthetic.

† As in three cases given by Mr. Banks: one, a labourer, unfitted for work, had become an inmate of a workhouse; the second was a wine-merchant, who had been obliged to give up his business, rarely venturing out, and then obliged to conceal his deformity under a large overcoat; the third, a glass-blower, reduced to perfect helplessness, had to depend on his wife for his support.

A Suggestion.

☞ TO THE DISPENSARY.

I was strolling one day in the old Colonnade, where we often used to wait
For a well-known Surgeon, whom I shall not name, who often turned up late.
When a timid little girl with a plaintive voice, said sadly unto me,
"If you please, sir, which way must I go to find the dispensaree?"
["Take the fourth door on the left, and pass 'neath the red lamp you will see."]
And scarce had I turned upon my heel, my vigil to maintain,
When a wizened old man, with a wobbling step, repeated the same refrain.
And so it goes on from day to day, as strangers seek relief;
But a word to the wise does oft suffice, so my song must needs be brief.

Passim.

To-night, at eight o'clock, the Physical Society will meet to listen to Mr. V. E. Collins on the "Comparative Histology and Physiology of the Sense Organs."

Our heartiest congratulations are due to Mr. A. Salter on having gained the Gold Medal in the recent M.B. Examination. Such a success fully upholds our excellent reputation, and sheds further lustre on the glorious name of Guy's. Just as we go to press, we hear of further honours, Mr. C. J. Harnett having gained the Gold Medal and Exhibition in Forensic Medicine, and Mr. Salter has gained further laurels in First Class Honours in the same subject.

Last Wednesday the first annual dinner of the United Hospitals' Cycling Association, was held at the "Horseshoe," Tottenham Court Road. The President, T. H. Openshaw, Esq., was in the chair, supported by Dr. Gilbard Smith. The following hospitals were represented: Guy's, London, St. Mary's, St. Thomas's and University College. The speeches showed not only that the Association was in a flourishing condition, but that it had every prospect of a successful future. A very good musical programme was gone through, Messrs. Martin, Millar and Henry being among the performers. The honorary secretary spoke of the proposed inter-club race meetings with Oxford and Cambridge Universities, and of the Cinderella dance which the Association will hold early in February. The "Mellin" Challenge Shield, for which we tied with London, will adorn the wall of our Club Smoking Room after January 1st.

We regret that, owing to a clerical error, Mr. L. H. Y. Stephens' name was omitted from the list of passes in Midwifery at the October examination of the Conjoint Board.

Dr. Silk, on Thursday last, delivered the first of the three lectures on Anæsthetics fixed for this session. The others will take place on the 12th and 19th, at 2 p.m., in the Anatomical Theatre.

The Committee of the Debating Society have determined to depart for once from the usual custom of Saturday evening debates, for, as an experiment, they will meet on Thursday, December 19th, at 7.30 p.m., when Mr. C. T. Anderson will move—"That betting and gambling in every form is demoralising." Mr. W. C. C. Pakes will oppose.

The Senior Charity will preside at the next smoking concert, which will be held on Saturday next, at eight o'clock, in the Club Smoking Room. It is to be hoped that in every sense it will equal our last effort in this direction, and, for this to be the case, volunteers in all branches of the art of amusement are required at once.

The contents of the Counting House post-bag are usually fairly prosaic. Mr. Williams was, therefore, a little startled the other morning by a request from a lady to send her "a pattern of the night-dress as advertised." Knowing that lunacy shows itself in strange forms, the application was duly confided to the care of the office waste-paper basket, and forgotten. A few days later another like application was received—this time enclosing ninepence for the pattern of "your night-dress." Mr. Williams is under the impression that his "night-dress" costs more than ninepence, and so returned the money to the address given—an hotel in the Midlands. A further post or so brought not only a pattern of "your night-dress," but a figure of a charming nymph inside it!! What! only ninepence? —but there, as we all know, the Counting House is far too respectable.

A great deal of sentiment, false and true, with morals in abundance as a garnish, has been served up by the *chefs* of the dailies and weeklies to a voracious public during the past fortnight on the sad death of Arthur Dacre and his wife. Theirs was the public view towards two members of the theatrical profession, ours that of a school mourning the loss of a brother, whom—worthy of our sympathy or not—we, at this period, cannot nor should not judge.

Under his real name, Arthur Culver James was a well-known figure at Guy's in 1868–1872, in which latter year he qualified as M.R.C.S.,

L.S.A., and later, in 1877, as M.D., at Aberdeen. There was no doubt that he possessed a moderate amount of dramatic ability, and the same may be said of the thoroughness of his work and his general genial character, but the whole seems to have been cramped and dwarfed by an excessive self-esteem and a high ideal of his own mission in life.

Intense interest was displayed by the students, patients and others on observing, on Thursday last, a crowd of harassed-looking persons of either sex—some severely branded by the hand of time—patrolling the Colonnade on their way to the medical wards. Strict inquiry elicited the information that they were the candidates for the dread degree—M.D. Lond., the clinical examination for which was being held here.

On Friday, November 25th, the Court Room at Guy's was the venue for the meeting of the Anatomical Society. In the absence of Professor Cunningham, Mr. Lockwood was in the chair. There were also present, among others, Messrs. G. D. Thane, Parsons and Percy Fleming.

We understand that the Governors have sanctioned the proposals of the School Staff to erect some new school buildings, consisting chiefly of physiological laboratories, in the south-west corner of the park, near and in the situation of the furthest Fives' Court. It is said that the court is to be pulled down at once, as operations for the foundations will commence as soon as possible. £12,000, privately subscribed, is to be spent on the scheme.

Arrangements for Christmas Festivities advance apace. Besides the usual "Nigger Round" on the 25th, we hear of the following entertainments promoted by the Residents and others:—

A Christmas Tree in Martha on Boxing Day, at 4.
Concerts in Naaman, on Dec. 26th, at 6

Eye Wards	"	26th, at 6.15
Stephen	"	28th, at 6.30
Accident	"	30th, at 3.30
Mary	"	30th, at 4.0
Job	"	30th, at 5.0
Philip	"	31st, at 4.0
Cornelius	"	31st, at 4.30
Lydia	Jan.	1st, at 5.30

So far as can be at present made certain, the following are the fixtures for the "Niggers' Tour" during Christmas week, commencing each evening at eight:—

December	28th.	St. Peter's Hall, Brockley.
	30th.	Public Hall, Peckham.
	31st.	St. Saviour's Baths, Southwark.
January	1st.	Public Hall, West Norwood.
	2nd.	Lecture Hall, Woodford Green.
	6th.	Assembly Rooms, Surbiton.

Besides the above, which are, so to speak, the official engagements of the "Dis-guysed," the niggers will appear—on December 20th, at the St. Olave's Parish Union; and on December 27th, before the Nursing Staff, in the Court Room; while on the 23rd, a portion of the troupe will journey to Emsworth, Hants, in aid of a local institution.

While on the subject of the Christmas festivities, we cannot leave it without a public acknowledgment of the value of Mr. Stanley Cock's posters, which he has specially designed for the occasion. We feel sure nothing could be more suitable or more excellently done, and his work must certainly, in a great measure, help to make the entertainments more successful.

We are asked to make a last appeal to those old Guy's men who have as yet neglected to come forward to take an active part in bringing before the notice of their friends these excellent endeavours, and the noble cause for which they are being made. Volunteers are especially needed for the West Norwood and Southwark Concerts.

H.R.H. the Duchess of Teck has kindly consented to allow her name to appear as a patron on the bills for the Surbiton Concert.

The members of the "Anomalies Dramatic Club" are ever to the fore in matters of charity, and in the present instance they are devoting their energies to the best possible cause—that of Guy's—for at 8 p.m. on Saturday, January 11th, they are giving an entertainment in support of the Sustentation Fund, at the St. George's Hall, Langham Place, W.

The general enthusiasm of outsiders working for Guy's is shown by the fact that, even now, all the tickets have been sold for the concert promoted by the South Eastern Railway, to be held on Monday evening next, December 9th, at 7.30 p.m., in the Bermondsey Town Hall. This speaks well for the loyal endeavours of all connected with the proceedings.

The Lady Pupils have no intention to be the last or least in their endeavours to aid this unfortunate Institution in its present mishap, for they inform us that they are about to give two performances on January 6th and 7th, in the Court Room. Each is to consist of a series of tableaux vivants, songs and music; at the former all the songs are to be by professionals, but, at the latter, the lady pupils and friends will have the whole entertainment in their hands. We agree with the promoters in "humbly hoping that some amusement may be derived from the entertainment."

Now that every effort is being made for Guy's by people outside—both employers of labour and old Guy's men in practice—a word of advice may not be out of place to impress on all engaged in the Out-Patients' departments, both in the Resident and more junior positions, the extra necessity of showing every attention, consideration and kindness to patients, their employers, and the practitioners by whom they are sent up—and that promptly. Many of them are sent here by persons who can, if persuaded by a kind act or word, do us a large amount of good—and the opposite is equally true; therefore, let us pay all due deference to public opinion, and be especially careful of every small detail in this respect on an occasion like the present.

We hear that there are a few Arthur Durham pictures for sale, at 10s. 6d., for the funds of Guy's, and also that several copies of the Biographical History are still for disposal.

With delight we have read the following in the *St. George's Gazette*. "Our entry of new students . . . has reached fifty-eight. . . It is partly owing to our limited number that our opportunities in the wards are so exceptional. Instead of being, *as is elsewhere the case, two or three dressers* to one patient, we are in the habit of being dissatisfied if, as dresser or clerk, we do not have charge of five or six patients." There is *nothing* of the Pharisee about this! But where, oh where, is the Elysium spoken of? [The italics are our own.]

Most men about the Hospital from 1889—94, knew and liked Mr. J. C. V. ("Skipper") Wilkins, and so we are delighted to give early announcement of his marriage on Thursday last for our readers to tender him wishes of good luck and prosperity in everything.

The new regulations of the Conjoint Board are before us, which date from November 22nd. These deal solely with examinations for students registered under the five years' curriculum, and the following are the chief alterations:—(1). The Elementary Anatomy has been omitted from the first examination. (2). Midwifery may be passed after four years' study, if one year after the Anatomical and Physiological examinations. (3). Pharmacology may be passed after four years' study, the Anatomical and Physiological examinations being complete. (4). Practical Pharmacy may be passed any time. (5). Medicine and Surgery are due at the end of the fifth year, there being two papers in the former subject. The Clinical examinations are to be increased in length.

Dr. Galabin will deliver the second of the series of Obstetrical Clinical Lectures in the Anatomical Theatre on Monday next at 1.45 p.m., the subject being "Encysted Peritonitis."

At the meeting of the Dental Society on Tuesday next at 4 p.m., Clinical cases will be shown.

We are sure that Messrs. Ash have earned the gratitude of all those who enjoy a laugh in their latest "Dis-Guysed" Programme. We have read, laughed, and possibly suffered, but we trust that the positive amusement which will be caused by it on the 25th, will repay "der little man," who has been annually responsible for the mental labour necessary for its publication.

The letter in another column, by the hon. assistant secretary of the Students' Club, has touched on a point, which—as usual, at this time of the year, when coats, umbrellas and macintoshes are in evidence—is provoking an increased amount of conversation and disgust; we refer to "lost property." We are forced to the conclusion that in certain cases the adjective should be changed into one less complimentary to the "finder," and that such should be the state of affairs, which from time to time is brought to our notice, without any apparent diminution of frequency, must be and is a disgusting and disgraceful thought to every true Guyite; so it behoves everyone—for the reflection rests upon us all—to discover and give impartial publicity to one such offence, for we feel sure this, and this alone, will eradicate the evil.

Presentation to Mr. C. H. Wells.

On November 10th, on the occasion of a meeting of the Staff of the Medical School, a presentation was made to Mr. Wells, in recognition of his services during the fifteen years that he has worked in the office of the Medical School.

It will be within the knowledge of most of our readers that when, in the early part of the year (owing to the financial needs of the Hospital), it became necessary to establish a special department for the collection of annual subscriptions, Mr. Wells was offered the position of head of the department.

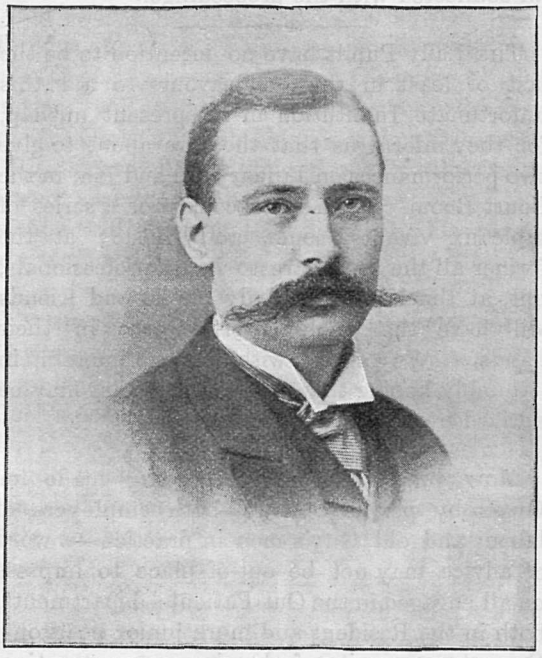
In order to satisfactorily fulfil the duties of this post he was compelled to relinquish his appointment in the Medical School, and his retirement was made the occasion for the presentation of a testimonial from the Staff.

Dr. Pye-Smith, in handing to Mr. Wells a marble clock with suitable inscription, together with a purse of sovereigns, expressed the regret of himself and his colleagues that Mr. Wells was leaving a position in which he had served so faithfully and successfully the interests of the Medical School, and spoke of the many important changes that had taken place during his period of office, in all of which Mr. Wells had given much valuable assistance.

Mr. Wells, in thanking the Staff for their valuable present, expressed the hope that in his new office he might be successful in furthering the interests of the Hospital, and might thus indirectly be the means of serving the School with even greater success than had attended his endeavours in the past.

Obituary.

Benjamin Hugh Lane.



Benjamin Hugh Lane, aged 35, son of Brigade-Surgeon B. Lane, late Army Medical Service, born January 12th, 1860, died November 14th, 1895, of diphtheria, after an illness of about three weeks, during which time he was under the constant care of Dr. Wohlmann, whose kindness and attention to him were extreme.

He was educated chiefly at a private school in Bridge of Allan, Scotland, where he was very successful, obtaining many prizes, and taking an active interest in sports. He entered Guy's in 1876, and in 1883, having taken the diploma of the College of Surgeons, went into practice in Bath, where he devoted himself to the study of the several rheumatoid joint conditions, a large number of which go for treatment to that city. He did a great deal of original work, and was regarded by his professional friends as a man of great promise, taking clear practical views of those diseases. He published several papers and books, perhaps the best known of which is a work on "The so-called Disease Rheumatoid Arthritis," which has been widely read and very favourably mentioned. He was completing a larger book when he died. He leaves a widow and two children.

Chapel News.

Contributed by the Chaplain.

The programme for the Three Days' Devotion for Nurses, on December 9th, 10th and 11th, is now in print, and copies can be obtained from the Matron's office or on application to the Chaplain.

On Wednesday, December 11th, an opportunity will be given to any *Nurse*, whether connected with Guy's or not, to join in the services, and the Treasurer, with his usual liberality, has offered the hospitality of his house to a limited number, taken in the order of their applications for admission. Such applications should be made to the Matron.

The "Lichfield Mission Hymn Book" will be used throughout the three days.

The subjects of the sermons for the remaining Sunday mornings of Advent will be:—

Dec. 8.—"The Unity of the Spirit."—II. Thes. iii. 14-15.
" 15.—"The Work of the Ministry."—Gal. ii. 9.
" 22.—"Charity seeketh not her own."—I. Cor. x. 33.

The subjects for Sunday evenings will be:—

Dec. 8.—The Intermediate State.
" 15.—The Judgment.
" 22.—Heaven and Hell.

The above will be taken in accordance with the "Simultaneous Sermon Scheme for the Rural Deanery of Southwark."

During Advent the Canticles will be sung to chants, and the Ante-Communion service will not be sung at all.

Offertories will be collected at all the Sunday services of Advent, and, with the exception of those taken at the celebrations, will be given to the Hospital Sustentation Fund.

Case of Diphtheria treated by Antitoxin.

C. S., æt. 4, a previously healthy boy, came under my care on the evening of February 17th, 1895. He had several attacks of vomiting on that day, and had been poorly for three days, with history of feverishness and sore throat.

When first seen there was some difficulty of breathing and laryngeal stertor. Temperature 102·6°; pulse 130; respiration 36. The tonsils and fauces generally were red and swollen, and on the left tonsil was a patch of membrane; the glands under both sides of the lower jaw were swollen and tender. No albumin in urine.

On the morning of the 18th the breathing was more difficult, and the fauces on both sides were completely covered with membrane. Temperature 103°; pulse 132; respiration 44. At 7 p.m. I injected 10 c.c. of antitoxin (obtained through Messrs. Allen & Hanbury) in the cellular tissue above left buttock, and another dose of 10 c.c. was administered the following morning. Improvement began within a few hours; the temperature and respiration fell, and the breathing became very much easier during the night following the second injection. The following day, February 20th, the membrane was disappearing, and two days later had completely gone, with temperature, pulse, and respiration normal. On February 23rd there was some swelling of the face, and an erythematous rash about the lower limbs; a cloud of albumin had also appeared on the 22nd, but these symptoms had all cleared away on February 25th, from which date the child made steady and rapid progress. There has been no paralysis. Chlorate of potash and cinchona were given throughout, and the throat continually swabbed out with a perchloride of mercury solution. A portion of membrane, bacteriologically examined by the British Institute of Preventive Medicine, showed the characteristic Klebs-Löffler bacillus.

Petersfield. H. M. BROWNFIELD.

Castration for Prostatic Hypertrophy.

A. D., a clergyman, æt. 69, had been troubled for the last three or four years with enlarged prostate, irritation of the bladder and constant need to pass his water, attended with some difficulty at times. He had been advised the use of catheters, but always declined it. Once in 1894, he was threatened with complete retention, but this was overcome by use of hot baths and general treatment. On April 9th, 1895, I was asked to see him by my partner, Dr. Leachman; there was complete retention due to a prostatic enlargement. The gland was very large, so that its upper limit could not be reached through the rectum. Attempts to pass a catheter having failed, Mr. Golding-Bird saw the patient in consultation the same evening, and after further futile attempts to pass a catheter, supra-pubic aspiration was resorted to. A tube was inserted and left in the bladder, by which means all his water was passed until April 29th, when a soft rubber catheter was introduced per urethram. The patient was now wholly dependent on the catheter, being unable to pass any water whatever voluntarily, and it was necessary to irrigate the bladder twice daily with an antiseptic lotion. After the matter had been fully explained to the patient, I performed double castration on May 27th. On the third day after the operation he passed a small quantity of water of his own accord, and although chiefly dependent on the catheter, the power of passing water naturally gradually increased and the catheter was less used, until once in twenty-four hours became sufficient. On June 24th the catheter was altogether discarded, and since then there has been a good flow of water with fairly continuous stream, and no difficulty in passing it. The patient's general health and condition continued to improve until

October 5th, when, after incurring a chill the previous day, he found on waking there was inability to pass water. A soft catheter was passed without difficulty, and afterwards he was able to urinate quite normally again. Unfortunately this temporary difficulty caused some considerable nervous shock to the patient, who dreaded the probability of returning to a life of catheterism, and occasioned a very slight cerebral hæmorrhage with partial right hemiplegia. This cleared up in a short time. The patient now, six months after the operation, is in good health, free from any difficulty in emptying his bladder, and says he is more comfortable than he has been for years; he can sleep for five or six hours, and can control his bladder for the same period during the day without inconvenience, whereas formerly he had been getting up almost every hour and micturating as frequently during the day. The prostate has been found, on rectal examinations, to be gradually decreasing in size, and now can be clearly limited to the size of a small chestnut, instead of that of an ordinary orange, the size of it before the operation.

This case, I think, is a very fair one, illustrating the influence of the removal of the testes in producing atrophy of the prostate; the small amount of shock and risk to the patient attending the operation, comparing so favourably with that of prostatectomy. As to the justifiability of the operation—notwithstanding the very severe strictures laid down on it by some very eminent surgeons—surely the success attending, and the relief given in such a case as the above, and in many other successful cases published, must warrant the operation performed on men of advanced age as a rational and justifiable one.

Petersfield, Hants. H. M. BROWNFIELD.

Correspondence.

To the Editor of Guy's Hospital Gazette.

In the "Charity."

"Trismus Uteri." "Continuous Obstruction."

Dear Mr. Editor,—First of all, may I be allowed to make a small correction in the initials which followed my name in the former communication? It was "F.R.S." I wrote, not "F.R.C.S." Secondly, with your permission I will give two examples which occurred to me, one in the "Charity," the other in Walworth, some years ago.

1. I was called in the evening to see a case of arm presentation. It was prolapse, and had been so from early morning. To correct this, the practitioner had essayed to turn by the feet, but, failing, went away for some hours and returned, again trying to turn, and then failing to do so, he again left the patient. After some time he sent for me. I found the uterus intensely contracted around the fœtus, the arm prolapsed externally, and the os uteri rigidly embracing the shoulder. The woman's pulse was 140, small, and her tongue was dry and brown. As chloroform had not been tried, she was placed under it. The pulse rapidly went down to 60; the anæsthetic was suspended, ammonia inhaled, the woman improved, and again chloroform was given, From that time she bore it well; but no relaxation of the uterus occurred. I tried to pass my hand between the fœtal shoulder and the uterus, but it was for only a short distance, and I could not reach the feet. The uterus was so firm that it resembled thick pasteboard rather than living tissue. I applied the crotchet to the pelvic end, then to the upper part of the fœtus to bring the neck within reach, but without result. I then got Ramsbotham's decollator round the body, and so destroyed the long axis of the trunk; but about this time the uterus began to relax, and the delivery was soon over. But it was the precursor of the end, and the patient died before the placenta could be delivered. The practitioner told me he had been called very early to this case, and not making then out the presentation, went away, and on returning found the arm in the vagina.

This case seems scarcely to require comment. It could hardly have been worse managed throughout the day. Had chloroform been given when the arm was first felt in the vagina, before pains came on, in all probability version would have been easy. Bimanual version had not then been described by me; but now the rule would be, if you cannot make out the presentation—the woman being in labour—and it appears to be oblique, rupture the membranes, and at the same time by the use of the external hand and internal one combined, bring either head or breach to present.

Continuous Contraction of the Uterus.

2. Another case occurred in the "Charity," and it was at the time before the present arrangement existed, when no "extern" was known, but when the "Charity" was worked by a "scratch crew," the first student who passed the porter's lodge was pressed into the service, who, when tired of the case, came away and left the friends to send up to get another chance attendant to go down—to effect which, the porter had to use all kinds of blandishments and persuasive ways, not always with effect. It was this case which was chiefly instrumental in causing me to make the arrangements which are now in operation.

A woman was in labour some three days. There was hard labour at first, and the attending student being tired out, sent another down, who in due time becoming tired, came away, sending a third. Neither of them had any account of the previous condition, and so gradually the bad symptoms came on without arresting their attention, because, as the rhythmical pains subsided, the continuous contraction insidiously came on, and thinking this to be merely a temporary rest of the uterus

they were deceived, and this deception was further fortified by the peculiar grin, mistaken for smiling, which is very characteristic of this phase of unrelieved labour. But at last a suspicion arose that all was not right, and I was called to see her. The pulse was rapid and steady, tongue dry and brown, sordes on lips, the grin well-marked. An offensive odour from the vaginal discharges, caused by the decomposing fœtus; os uteri open, hard and rigid. The whole uterus was tightly grasping the fœtus hard and firm, as if made of wood. The head inside the os, about the middle of the pelvis. It was arrested by a slight want of relationship between the head and the bony passages, which was soon overcome by the forceps; a putrid child was delivered; the placenta gave no difficulty, but the uterus remained rigid and its cavity was not closed so as to expel the placenta, though there was no hæmorrhage. She survived five days, emitting putrid fœtor from her body generally all the time, dying from the absorbed septic products.

Now some of these cases begin very early, as in the case I saw with Dr. Roper, before the rhythmical contractions fairly begin, and these will get into this dangerous state before the medical man arrives. I have seen this occur with placenta prævia at six months' period. In these, expulsive action is neutralised by the grasping from the first. But whenever it occurs we are able to recognise it, as I have pointed out; and it is our duty in being called to a case of labour to make out whether it be normal or not, instead of letting it go on till danger is recognised too late to remedy. And during every labour it should be our rule to note, from time to time, not only the progress of the fœtus, but also the state of the motor force both during and between the pains.

It will be a great point gained if we clearly understand that when once the continuous action has usurped the place of the normal rhythm of labour, it is useless to expect unaided delivery; and though, in the early stage a small dose of opium—or a moderate inhalation of chloroform—may so far relax the grasp that the expulsive action may deliver, yet we must not wait when these fail, but assist according to the presentation. Yet while urging action in the case of trismus, it must be clearly distinguished from simple quiescence of the uterus: generally the diagnosis is simple.

J. BRAXTON HICKS, M.D. Lond., F.R.S.

The Students' Club.

Sir,—Will you allow me, through the medium of your columns, to give more publicity to several important matters relating to the management of the Club and which do not appear to be generally known? There has been of late a very reasonable complaint as to the right of reservation of seats in the reading-room. This has never been recognised in the past, and the committee do not think the general convenience of members would be served by legalising such a custom.

A second complaint, which has been more than once brought before our notice, is begotten by a distinct breach of the rules. It is to the effect that the Club magazines and journals are taken away from the reading-room by certain of our members—and this particularly upon Sundays. It is a matter in which every member of the Club has his responsibility, as is plainly indicated in Nos. 5 and 6 of the general bye-laws, page 57 of the blue book. It is to be hoped, therefore, that there will be no occasion to carry out the stringent resolution passed at the last committee meeting, viz.:—"That if bye-law 5 be not adhered to, the only alternative is to withdraw the magazines and journals from use on Sundays."

With regard to the notice concerning "Lost Property," which has recently been affixed to the board in the smoking-room, I should like to draw attention to a few points. It must be distinctly understood that the committee of the Club do not hold themselves responsible for the safety of any article left upon Club premises. The Medical School provides a cloak-room for the use of junior students, and many of those in the wards have the use of lockers. There is no doubt that if those members of the Club to whom it is convenient to use these safe receptacles would make it expedient to do so always, the cry of "lost," "borrowed," or what-not, would be less frequently heard. I am aware that this would not constitute a cure for "Kleptomania," but as a certain amount of losses are due, undoubtedly, to sheer carelessness, it follows that the exercise of a little thought and perspicuity by the majority of our members would, at any rate, mitigate the evil. The committee for their part are doing the best they can, and if those members who lose or find articles will but communicate *at once* with the College porter, much more may be done. The want of system has hitherto bothered everyone, and early notice is what the committee desire most. Even now there is in our possession an article of considerable value about which no enquiry has as yet been made, and this is the sort of difficulty they are constantly placed in—total ignorance as to the names of owners of lost property.

For some time past, there has been a tendency of those members who take lunch and tea in the dining-hall, to smoke, in open defiance to bye-law No. 9. Unfortunately, this is a tendency which soon becomes a habit. It may, perhaps, seem a small thing to cavil at, but it should be known by all that smoking is absolutely prohibited in the dining-hall until after 6.45 p.m. This rule was passed by an overwhelming majority at a crowded general meeting some five years ago, and it is the intention of the committee, as it is the duty of every member of the Students' Club, to see that bye-law is not infringed in the future. Thanking you in anticipation for the insertion of this letter,—I am, sir, your obedient servant,

THE HON. ASSISTANT SECRETARY.

First F.R.C.S. Viva Voce Exam.

ANATOMY.

Candidate A was shown a left humerus. Asked the muscles attached to it. Mark out insertion of those going to great tuberosity. Which is the anterior border? What muscle is attached to the back of the internal condyle? What muscles arise from the common tendon on this condyle? What is the supracondyloid process? How does it modify the relations of the brachial artery? What muscle arises from it? What converts it into a foramen? Ossification of humerus. Do the centres at the lower end join the shaft separately? How do they join it? If you made a vertical section through the upper end, what would you see? How is the cancellous tissue arranged? What are the causes of the curves in the head and in the tuberosities of the bone?

What causes the direction of the musculo-spiral groove? The twisting of the shaft outwards. What are the anatomical and fœtal positions of the upper and lower limbs? How much are each deflected from the latter to attain the former? By how much of a circle, then, does the position of the arm differ from that of the leg? The examiner gave candidate an interesting demonstration on this point. Candidate was shown a femur, and asked its centres of ossification and their dates.

Soft parts.—A dissection of the suboccipital triangle. Distinguish the various muscles in relation with it. (These were cut off short). Nerve supply of muscles forming it. Peculiarity of second cervical nerve. How many interspinales and intertransvales are there attached to the fourth cervical vertebra?

Candidate was then shown a pickle of the dorsal vertebræ, and parts in immediate relation to it. What is the length of the œsophagus? Where does it commence? What is its nerve supply? Where do the vagi end? Which goes to the liver? How does it get there? What is the foramen of Winslow? What is the difference between the right and left intercostal arteries? [*Bell.*

PHYSIOLOGY.

Candidate shown two specimens of spinal cord, one prepared by Golgi's and the other by Weigert's method. What are these methods? Describe how you would stain a tissue with silver nitrate. What does the salt stain? What is the chief nitrogenous body in urine? How much urea does a man pass a day? Candidate's answer was in grammes, but he was asked to convert it into ounces. What other bodies are there in urine? How much sodium chloride is passed a day? Answer wanted in English weights. Candidate shown some bread. What are its constituents? Where do you find the dextrin? Have you ever analysed bread? Have you ever made gluten? How did you do it? How much proteid is there in bread? What is gluten? What is there peculiar about it chemically? How do you classify proteids? How do you distinguish globulins from albumins? Candidate shown test tubes in which the following tests had been done with proteids:—xantho-proteic, Millon's, Biuret, copper sulphate and caustic soda with a peptone solution. He was asked to distinguish them. He was next shown a large model of the middle and internal ears. How is sound appreciated? How do you know the ossicles move? Have you ever seen them move? Can they be seen to move? To what rate of vibration will the tympanum respond? What is the use of the semicircular canals? How do they act? What evidence have you in support of your answer? How is voice produced? What is the difference between voice and speech? How are vowel sounds produced? [*Bell.*

ANATOMY.

Candidate B was given a fifth metatarsal and asked the side to which it belonged, ossification, and muscles attached to it. Examiner pleased with Wood's muscle. Have you ever seen it? When not present as a muscle, how is it represented? Does the transversus pedis really arise from the bone? A scaphoid in the hand next given and the different articular surfaces mentioned. Ossification of the os calcis. Mark in the line of the epiphysis. Is the tendo Achillis attached to it? Are the tubercles part of it? Ossification of the astragalus. Has it ever a second centre? Where is it? Ossification of the other bones of the tarsus. Ossification of the temporal bone. Point out the six centres for the petrous and mastoid portions. What is the condition of the styloid process at birth? What is the shape of the tympanic plate? How is the membrana tympani inserted into it? Point out the articulations of the temporal bone. What are the bony boundaries of the jugular foramen?

Candidate next taken on soft parts. A thorax with the heart and lungs removed. What arches over the root of left, what over right lung? Point out the great azygos vein. Is that its normal size? No. Why not? Full of injection. What are the variations of the aorta? What happens to the recurrent laryngeal nerve, thoracic duct, and abdominal viscera where there is a right aortic arch.

Candidate next taken to anterior triangle of neck, and asked to point out the different structures to be seen. Relations of occipital artery. What is the relation of hypoglossal to it? While candidate answered, examiner's hand was carefully held over part. Nerve supply of anterior belly of digastric. Where does the nerve enter the muscle. Origin, insertion, action and nerve-supply of crico-thyroid. Nerve-supply of thyro-hyoid. It is really a branch of the hypoglossal? [*Bell.*

PHYSIOLOGY.

Look down that microscope. What is the specimen? Section of cord? How is it stained? Golgi's method. How do you know? No coverslip. Describe Golgi's method. What is this next specimen? Secreting gland.

Can't you get any nearer? Thyroid. Is that a secreting gland? Yes. How is it developed? How are the branchial clefts developed? How the arches? What does each arch contain? An artery. What do these arteries become in the adult. What organs are developed in connection with the arches? Thyroid, thymus, tongue.

Here is a specimen of urine. How much urea does it contain per cent.? How much urea is passed daily? What are the salts of urine? How much nitrogen is passed daily? Where does it come from? What is the effect of work and starvation on the excretion of urea?

Candidate next taken over an induction coil. How do you arrange it to show minimal stimulus? How can you get rid of the break effect? Why is the break effect of an induced current greater than the make? [*Bell.*

Immediate Treatment of Irregular Teeth.

THE last two meetings of the Odontological Society have been chiefly devoted to the consideration of a proposed rapid method of correcting dental irregularities. In the first cases operated on the tooth was protected by tinfoil or some other suitable material, and was then grasped by the forceps and drawn into proper position. One may assume that incidentally the alveolar process was cracked or fractured. Sometimes the pulp died and the tooth was discoloured, at other times it remained loose, but the results were considered favourable on the whole, and very considerable advance has since been made in the method of operating. A very thin circular saw is used on the dental engine, and a cut fully an inch in depth is made on each side of the tooth, or series of teeth, that is to be moved. In this way the teeth and the alveolar depressions in which they are contained can be forced into good position with much less danger to the vitality of the dental pulps; and a ligature or small splint can be used whilst union is taking place. The method resolves itself into a simple plastic operation, which can be performed in every case with a strong prospect of success as regards union, but the limitation of cases suitable for operation is a matter worthy of grave thought.

Hitherto it has been the practice to correct irregularities in the position of the teeth by pressure brought to bear upon them by means of "correction plates." In very simple cases a few days only may be necessary, but in exceptional instances one year, or even two years, may be required. Any attempt to move teeth quickly produces pain, and defective correction plates are so uncomfortable that even good children sometimes carry them in their pockets, and thoughtless schoolboys break them under foot. Illness and holidays often interrupt the work, and occasionally lead to utter failure after months of treatment. Moreover, it must be admitted that badly-fitting correction plates are prone to favour dental caries by retaining food, especially if they be not scrupulously cleaned. Further, by pressure brought to bear on the crown of a tooth, we cannot expect to alter the position of the apex of its root, whereas by a plastic operation the whole of the tooth can be moved. The above arguments are advanced in support of the new treatment, and doubtless there are cases where prolonged mechanical treatment cannot be obtained or would not be accepted, and others where the usual methods have been tried and have failed from causes that were unavoidable or inevitable; but resort should not be made to the circular saw until we have convinced ourselves that success by gentler methods is unattainable. A number of cases were shown at the Odontological Society, some of which could certainly have been treated very successfully without operation, and others there were which represented the failures of usual treatment without adequate cause for failure being apparent. However carefully we may select our patients for plastic operations we must expect bad results occasionally, and the loss of incisor teeth and their sockets would be a very serious matter for a boy, and even worse for a young woman. These operations will probably clear up the doubt that exists as to repair by bone after fracture of the superior maxilla, at least as regards the alveolar process. If clean saw-cuts be carried through the alveolus at the time of teething, when the bony sockets are in a state of active development around the erupting teeth, one would expect to get bony union.

F. NEWLAND-PEDLEY.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the GAZETTE PATHOLOGIST, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

G. F. H., BALHAM.—After twenty-four hours' incubation on blood-serum, the resulting growth was found to consist of Klebs-Löffler bacilli in pure culture.

S. W. M., SOUTH PETHERTON.—No tubercle bacilli could be found in the sputum.

F. K. H., HAMPSTEAD.—No tubercle bacilli could be found in the sputum.

PATHOLOGIST.

Physical Society.

A Meeting of the Physical Society was held in the Library, on Saturday, November 23rd. The evening was devoted to the exhibition of pathological specimens, and a very interesting and instructive display resulted. The following list includes the more important items and short notes of the cases:—

Mr. M. A. Key.—A perforated appendix cæci, removed by operation from a little girl of seven. The operation was performed fifty-three hours after an abdominal injury. The appendix was found to contain a large concretion like a date-stone, and there were two perforations in its wall.

Mr. Ham.—A severe example of ulcerative colitis in which perforation had taken place and caused peritonitis. During life the case was regarded as one of typhoid fever or typhlitis.

Mr. T. B. Poole.—A much thickened calvarium from a man, aged 39, who died of cerebral hæmorrhage. The causation of the thickening was discussed. It was thought not to be syphilitic, because of the smoothness of the external surface, and the uniformity of the thickening. The inner surface was deeply grooved by the meningeal vessels, as in osteitis deformans, but the distinction between the outer and inner tables was not wholly obliterated, as in Paget's disease. The man was a fish-porter; hence the probability of the lesion being due to "pressure changes."

Mr. Parry exhibited the proceeds of an operating theatre during the past few months. In addition to numerous ovarian cysts, uterine fibroids, and cancers of the tongue and breast, there was a sarcoma of the orbit of a boy, supposed to have originated from Tenon's capsule and not from the periosteum. It had protruded the eye-ball. A hydronephrotic kidney, considered to be due to a traumatic stenosis of the ureter following an abdominal injury ten years previously, excited much interest, and the explanation offered was rejected by the majority of the speakers. Inasmuch as there was an irregular discharge of pus from the bladder, it seemed likely that the obstruction of the ureter was related thereto.

Mr. Partridge.—A leucocythæmic spleen. An example of endocarditis of the pulmonary valves in a young man, probably due to gonorrhœa.

A calculus impacted in the right ureter of a girl aged nineteen, who died of suppression of urine, the left kidney having been previously excised for tuberculosis. The calculus could have been easily removed by operation.

Severe syphilitic aortitis from a man who died suddenly, the vessel having ruptured into the pleural cavity.

Mr. Sharp.—Several specimens which were supposed to show syphilitic disease of the joints.

Mr. Anderson.—A very large renal calculus.

Mr. Peters.—A dilated pancreatic duct from a case of diabetes. The duct contained many calculi.

Heredity.

A Paper read before the Physical Society on Saturday, November 9th, by Mr. Philip Turner, B.Sc.

Mr. Chairman and Gentlemen,—Before I begin to speak about the subject which we are to discuss this evening, I feel that I must thank this Society for the great honour conferred upon me in asking me to read a paper.

I venture to think that my subject,—Heredity, notwithstanding the article in this morning's Gazette, needs no apology, for it is one in which we must all take a certain amount of interest, and one of those biological problems with which we should all endeavour to be familiar. One of the great difficulties with regard to Heredity is the enormous mass of facts and speculations which have accumulated as the result of recent researches, and the many interesting side issues with regard to other biological problems. I had at first thought of choosing such a side problem, but afterwards came to the conclusion that it would be more interesting and even more useful to consider the main issue. In this paper, then, I shall endeavour to bring forward some of the more interesting facts, and examine them according to the more important theories.

Heredity has been defined by Herbert Spencer as "The capacity of every plant and animal to produce other individuals of a like kind." It is also necessary to recognise that the offspring never exactly resembles the parent, but always presents certain differences which may be small and unimportant, or well-marked and striking. Some of the older writers spoke of two antagonistic forces acting on all living beings: Heredity—a force tending to make the offspring resemble the parent, and Variability—a force tending to make the offspring differ from the parent. These two forces, however, are so constantly found acting together, that they must be considered as the result of one and the same force.

The phenomena of Heredity may be subdivided as follows:—

1st. We have to consider those features in which the offspring resembles the parent, or repetitive phenomena. These are so common and appear so natural that one is tempted almost to overlook their importance. Under this head, however, we must class those cases where the offspring shows characters, derived, not from the immediate parents, but from more or less remote ancestors, which are not seen in the intervening generations, and in many cases have been latent for a large number of generations. This remarkable fact is known as Reversion, or Atavism.

2nd. Characters in the offspring which were not present in the parents, but which are new. These may be termed the non-repetitive phenomena.

3rd. The embryological side of the question; or how is it that from the simple ovum the multicellular organism is developed, and how is it that the characters of the parent may be so minutely transmitted to the offspring

by its development; or, in other words, the mechanism of heredity.

The phenomena which fall under the head of Reversion are among the most remarkable and interesting in connection with heredity. Even when seen in its simplest case, where a child has certain characters which were seen in grandparents and not in the parents themselves, this is a striking fact. For instance, where a man resembles his maternal grandfather in certain exclusively male characters which his mother must have transmitted in a latent condition. But when the reversion is to the characters of much more recent ancestors—and we must assume that characters have been transmitted in a latent condition for many generations—it is seen that the mechanism for the transmission of these characters must be very complex.

Darwin collected many examples of reversion, especially with regard to domestic animals which have been much modified by selection, and, especially when different breeds are crossed, and, occasionally spontaneously, tend to reproduce ancestral characters. There can be no doubt, however, that many of the phenomena usually referred to reversion should more correctly be explained in other ways. For instance, the occurrence of extra digits in man and in animals has been regarded as a reversion to the condition of some unknown prehistoric ancestor possessing a greater number of digits than five. Similarly, in the case of the horse, extra hoofs are sometimes found; this, again, has been referred to reversion to those prehistoric ancestors of the horse which had more than the single digit developed. Such ancestors certainly have existed, but it is far more probable, that the greater number of these cases should rather be explained according to Weismann's theory, by the doubling of those determinants in the egg cell which give rise to these parts, and not to the presence in the germ cell of minute representatives of the germ plasm of these exceedingly remote ancestors.

I expect many of us read in the *Lancet*, some few weeks ago, of an ingenious theory which explained colour-blindness as an example of reversion. According to this view, colour-blindness—which *usually* consists of an inability to distinguish between red and green—is due to a reversion to the condition of ancestors who lived ages ago, when the sun was much hotter and gave out a bluish white light instead of a yellow light as at present. When the sun was in this condition, the red rays would be practically absent from the spectrum, and hence there would be no need for eyes to appreciate this red light.

This is an ingenious theory, but cannot be well supported; for, after the lapse of so many generations as must have existed in this case, all representatives of the germ plasm of these ancestors must have been eliminated long ago, or only be present in very rare cases. Colour-blindness, however, occurs in four out of every hundred males, and four out of every thousand females. Colour-blindness in a healthy man is nearly always hereditary, and may often be traced for several generations in one family. This usually occurs in a very interesting way, for the daughter of a man who is colour blind may have normal colour-vision and yet transmit the abnormality to her sons.

The importance and significance of the appearance of new characters or variations was first pointed out by Darwin. Thus, although the physical nature of the parents is transmitted to the children, yet this transmission is never accurate, for the offspring never exactly resemble one another or their parents. This might in part be accounted for by the unequal blending of the characters of the parents, and by reversion; but this, as Darwin points out, is no true explanation, but only pushing the difficulty further back, for what made their progenitors different? The importance of these new characters is that—though we know so little about the cause of their appearance, yet they are almost always inherited, whether they be large and striking—when they are usually known as monstrosities—or whether they be so small as to be practically unseen. It is these small variations which are of such importance, for it is on these that natural selection acts, while the more striking variations, such as the appearance of extra digits, soon become lost by crossing with normal forms. The inheritance of these small variations may be seen in those parts of the body which are classed as degenerating structures, such as the frontalis muscle and the little-toe. In these cases the degeneration can only be observed after numerous generations, and yet we must assume that the total degeneration is the sum of innumerable small variations—very possibly the results of disuse of these parts.

Darwin considered that the appearance of these new characters was due mainly to the action of external influences, such as climate, nutrition, use and disuse, acting in some cases directly on the organism, and sometimes indirectly through the reproductive system. The action of these agencies on the organism is universally admitted, but the question as to whether the changes thus produced are inherited is the subject of great controversy.

The embryological side of the question is one of the most interesting, for it involves the question of the mechanism by means of which characters are transmitted from parent to offspring. It is obvious that, in seeking an explanation of development, two possible views are open. The egg cell may be regarded on one hand as actually containing within itself representatives of all parts of the future organism, or the organism may be regarded as arising from a process of growth and differentiation of the original cell. The first of these suppositions assumes the preformation of the adult in the germ cell, and most theories assume this principle. On the other hand, there is much to be said in favour of the opposite view.

The first to suggest a theory of Heredity was Democritus (B.C. 450). His theory bears a certain resemblance to that propounded more than two thousand years afterwards by Darwin, for he regarded the sperm in each sex to be derived from all parts of the body, and

that like parts gave rise to like. Aristotle also considered the problem, and in his "Generation of Animals" says, "Children resemble their parents not only in congenital characters, but also those acquired in later life, for cases are known where parents have been marked by scars and children have shown traces of scars at these spots." He also considered that mutilations might be inherited, but that this was rare. Darwin's theory was also foreshadowed by Manpertuis (1698), who considered that the elementary particles forming the embryo are derived from all parts of the body of the parent. He also attempted to explain the appearance of monstrosities, of hybrids and of reversion, as due to certain particles being missing, to mixing of particles and presence of particles derived from ancestors respectively. Lamarck, at the beginning of the present century, brought forward a system of Heredity in which he introduced a law which is the subject of keen controversy even at the present day. This is his law of the transmission of acquired characters, which states: "That all that has been acquired or altered in the organisation of individuals during their life is preserved by generation, and transmitted to new individuals which proceed from those which have undergone the changes." This law is strenuously denied by Weismann, and certainly is not true to the extent imagined by Lamarck, for he did not recognise the action of natural selection at all, but explained all changes in the organism as due to the inherited effects of use and disuse. It must still be regarded as an open question to what extent Lamarck's law holds good.

Herbert Spencer's theory is of interest, because it may be regarded as the starting point of the more recent theories on this subject. He regards the organism as composed of complex groups of molecules, which, however, are not cells and not molecules, but physiological units composed of complex groups of molecules, and that in these is the intrinsic property of aggregating or crystallising into the form of the animal. The germ cell is supposed to contain small groups of these units, and has thus the power of reproducing the whole.

Darwin, after he had collected together an enormous mass of facts connected with inheritance and variation from the study especially of domestic animals, saw the necessity of bringing all these facts under the same head, and of propounding a theoretical explanation which should explain all these facts in a similar manner.

Darwin's theory of Pangenesis supposed that all the cells of the body of a multicellular animal possessed the power of giving off, at certain stages in their development, extremely minute particles, which he called gemmules. These passed into the circulation, and eventually settled down in certain regions of the body, usually in the germ cells. In those animals, however, which have the power of regenerating lost parts, such as newts and salamanders, these gemmules were also regarded as being collected into the parts which were capable of regeneration. Each gemmule was assumed to have the power of giving rise, at a later period, to a cell similar to that from which it was budded off. The ovum is thus considered to contain a vast number of gemmules drawn from cells all over the body—hence the name Pangenesis. Reversion is explained by assuming that there are also present gemmules derived from the parents and more remote ancestors. Thus, when the ovum developes, certain only of the gemmules give rise to the cells of the adult, the remaining gemmules remaining in a latent form, and so becoming transferred to the offspring. This theory does not seem to differ essentially from that of Mr. Spencer. An obvious weakness in Darwin's theory is that no explanation is given of the mechanism which ensures that each gemmule shall be in the right place and in the right time, but Darwin himself regarded this theory as only a provisional explanation.

Darwin's theory added a great stimulus to the study of Heredity, and several modifications of it were soon propounded by other writers who saw its weakness and its strength.

We have now to consider Professor Weismann's theory, which is certainly the most complete theory of Heredity which has been put forward, for in addition to explaining the phenomena of Heredity it also embraces a theory of evolution and raises up many side issues. Weismann's first essay on Heredity appeared only two years after the death of Darwin, in 1883, and since that time he has in many respects revolutionised biological thought.

The essential part of Weismann's theory is that in all animals a sharp division of the cells of the body into somatic or body cells and reproductive cells can be recognised. These two classes of cells are supposed to be essentially separate from one another, the somatic cells merely forming a case for the nourishment and protection of the reproductive cells. The power of reproducing the adult organism possessed by the germ cells depends upon the fact that they contain the germ plasma—substance which can never be formed anew, but which must always be derived directly from the germ plasm of the parent.

In one respect his theory resembles that of Darwin, for he assumes the presence in the egg cell of minute and quite hypothetical particles which represent the various organs, tissues, and cells of the adult; the difference, however, being that Weismann regards these particles to be contained in the nucleus of the egg cell only. To these particles he gives the name of biophors, the difference between the various tissues—for instance, muscle, nerve, bone, and so on—being due to their cells being composed of different kinds of biophors. The more highly differentiated cell must consist of several different kinds of biophors, corresponding to the histological differences which can be made out in the different parts of the cell. These biophors are supposed to be arranged into certain definite groups, forming units of a higher order, the determinants; thus each cell in a multicellular organism is controlled by such a determinant, including

growth and rate of division. It is not necessary, however, to assume that every cell in the body is represented by separate determinant in the germ plasm; for instance, Weismann assumes that in the case of blood cells of a similar kind, they may be all represented by one determinant, which afterwards multiplies by division. But he insists that every cell or group of cells which is independently variable must be represented in the germ plasm by a special determinant. Weismann assumes that all the determinants representing the various parts of the organism must be again built up into a still higher unit, the Id, which contains all the determinants and biophors arranged in a certain definite manner, necessary for the development of the animal.

The germ plasm does not, however, consist of a single Id, but a large number, these being derived from the germ plasm of more or less distant ancestors, and thus the phenomena of reversion are explained. The germ plasm thus has a definite structure, and in the divisions of the egg cell during development, Weismann imagines a method sorting out of the determinants in the proper order into their proper places. In the complicated process of division of the nucleus by Karyokinesis, he sees a mechanism for ensuring the exact division of the nucleus. With regard to the size of Weismann's units but little can be said; he, however, regards a single chromosome of the nucleus of the egg cell as consisting of a number of Ids, each of which contains all the determinants of the species.

It is, of course, in a brief paper like this, absolutely impossible to do justice to Professor Weismann's theory, but it would be well to look at the way in which he explains some of the more important facts. He regards sexual reproduction as a means of causing variability in the offspring, ensuring that no two offsprings shall exactly resemble each other. This idea seems also to have been recognised by Darwin, though he gave no explanation of the fact. The polar bodies are regarded as getting rid of a certain amount of germ plasm by eliminating certain of the Ids. Similar reducing divisions are also regarded as occurring in the male cells, only in this case the halving does not lead to the formation of polar bodies, but of two dissimilar male cells. It is assumed that in this case the complicated germ plasm *cannot* divide in the same way in any two ova, and that hence, when ready for fertilisation, it is scarcely possible that two ova can contain the same combination of Ids, so that no children can exactly resemble one another or their parents. According to Weismann's latest view with regard to the formation of the polar bodies, if only 16 Idants be present, 258,570 possible combinations are possible, with 20 Idants 8,533,660 combinations, and so on. In the case of identical twins, where two children are almost exactly alike, there is every reason to suppose that both are developed from one ovum and spermatozoon, a division having occurred after fertilisation. It is interesting to note that identical twins are invariably of the same sex, thus proving that the sex must be predetermined in the fertilised ovum. Darwin mentions a case of two girls, evidently identical twins, in all respects extremely alike. Each had the little fingers on both hands crooked, and also the second bicuspid tooth in both children was displaced; instead of growing in a line with the others it grew from the roof of the mouth behind the first bicuspid. Neither of the parents nor any members of the family had ever been known to have exhibited these peculiarities. Darwin argued that as these abnormalities occurred in each of the children it could not be due to accident or to chance, but to some cause which was unknown. According to the present view it is due to the two children having arisen from the same germ plasm, which was of abnormal structure. Weismann also examined identical twins, and while the resemblance was remarkable, yet on carefully examining and measuring he was able to detect differences which he attributes either to the action of unequal nutrition or other external influences, or to an inexact division of the nucleus of the fertilised ovum.

One of the most remarkable facts is that certain characters may be transmitted, disappear for one generation, and then reappear. The most obvious instance of this is the transmission of certain distinctively male characters, such as a beard, or voice, from a man through his daughter, in which they are necessarily latent, to his grandson. These characters may be termed secondary sexual characters, and we must assume that in each sex the secondary sexual characters of the other sex are present, but in a latent form. Weismann explains this by supposing that in the germ plasm determinants for the secondary sexual characters of both sexes are present, so that the sex is decided by either of these series of determinants becoming active, according as the germ cells take on a male or female character. There are also some facts which tend to show that these latent determinants are represented in the adult as well as in the germ plasm; for instance, when a hen becomes sterile from age it has occasionally been observed that the plumage, voice, and other characters of a cock are assumed. The reverse is also true, for if a young cock be castrated, the comb, wattle and spur do not grow, and the animal tends to assume an intermediate character between male and female. An interesting case is seen in crabs, which are attacked by certain parasites which destroy the reproductive organs; the result is that in external characters these animals become intermediate between males and females. Similar phenomena to the above may be witnessed in mammals and even in men.

The condition known as hæmophilia is interesting since it is hereditary, and in its mode of transmission resembles a secondary sexual character.

This disease occurs in men only, and yet is transmitted through the female members of a family. Thus, the condition may be transmitted from a man to his grandson through his daughter, in whom it is not seen, but must be represented in a latent condition. The disease is not in any way connected with the sexual organs, but

depends upon an abnormal condition of the walls of the arteries, so that upon slight injury there is serious hæmorrhage. This condition must then be due to some defect in those mesoderm cells from which the blood vessels are developed, and thus the determinants which govern the cells must have varied in some way in the germ plasm. Since this disease occurs only in men, we must suppose that the blood-vessels, though apparently similar in the two sexes, must really be represented in the germ plasm by two series of determinants, which can vary independently, one of which has the power of giving rise to male blood-vessels, the other to female blood-vessels. Hæmophilia would thus be assumed to have originated first in a male individual, and so to have affected the male determinants only. The fact that new characters often arise in one sex, and then are transmitted only to the same sex, of which he gives many examples, was recognised by Darwin. As has already been pointed out, colour-blindness is inherited in a like manner, and this is also the case with other conditions. These facts may be explained by assuming that all or nearly all organs of the body are represented in the germ plasm by a double series of determinants, and that in all these cases the male or female determinants may vary independently of the others. This, of course, must introduce a great complication into the structure of the germ plasm.

According to Weismann's theory, there are three ways in which diseases can be inherited. The first of these is by a pathological variation in the germ plasm, under which heading we must class those cases, such as hæmophilia, which have just been mentioned. Many congenital deformities may doubtless be explained in the same way.

Under this heading should also be classed such deformities as polydactylism, which have been by some regarded as examples of reversion. They cannot, however, be explained by the presence in the germ plasm of determinants derived from exceedingly remote ancestors, for extra digits are always provided with a nail and not with claws, as must have been the case with such ancestors. These should rather be explained as due to a doubling in the germ plasm of the determinants for these parts, due perhaps to excessive local nutrition. In the same way the disappearance, or ill-development of certain parts, may be explained as the result of deficient nutrition of these determinants, and so malformation is caused. If this is so we should expect that after several generations crossing with normal individuals would assure their elimination, and this agrees with the fact which has been observed that supernumerary fingers never persist for more than five generations.

The second method of transmission of disease is not connected with heredity in the true sense of the word, for it does not involve any change in the germ plasm itself, but depends upon an actual infection of the germ by specific micro-organism of the disease. To this class may be referred the transmission of syphilis, and probably also other diseases depending upon the presence of a specific microbe.

There is one undoubted example of such a mode of transmission in the lower animals. This is seen in the pebrine disease of the silkworm, which depends upon the presence of the spores of the fungus causing the disease, in the yolk of the egg cell. Weismann also explains the experiments of Brown Sequard on guinea-pigs in this way. Brown Sequard, by injuring the spinal cord and larger nerves in guinea-pigs, was able to produce epilepsy which was inherited by their offspring. This would really seem to be an example of the transmission of an acquired character, but Weismann assumes that the disease produced was really due to microbes, and that the germ cells of the guinea-pigs were infected by these microbes!

In the third place, a disease may be inherited by the transmission of certain predisposing causes, predisposition being the power of reacting to a stimulus in a certain way, the stimulus consisting in the presence of micro-organisms or other external agencies. This is a true case of inheritance, for it depends upon the transmission of a constitution. Hereditary tuberculosis might possibly be explained in this way, a constitution with certain structural peculiarities which form weak spots for the attacks of the tubercle bacillus being transmitted. Weismann mentions the case of a soldier who lost his left eye as the result of inflammation following an injury, and afterwards had two children, both of whom in after-life developed ophthalmia in the left eye. This case has been brought forward as an example of the transmission of acquired characters, but Weismann's explanation seems more probable.

It follows, necessarily, if Weismann's theory be true, that acquired characters are not inherited, for the reproductive cells are essentially and primitively separate from the somatic or body cells. Thus it follows that variations and changes produced in the soma or body by external influences, such as climate, nutrition, use and disuse, can have no influence upon the structure of the germ plasm, and as the structure of the offspring depends upon the composition of the germ plasm, they cannot be reproduced. Acquired or somatogenic characters may be defined as "Those which are not performed in the germ, but which arise only through special influences affecting the body or parts of it."

The great importance of this problem has well been pointed out by Mr. Herbert Spencer, who points out that if acquired characters are inherited, we have a very powerful means of improving the community, for if each generation be well trained both bodily and mentally, and these improvements, the effects of use, be inherited, in the course of generations, this will lead to the improvement of the human race.

Many of the examples of the inheritance of acquired characters which have been brought forward, of which one or two have already been mentioned, are not acquired characters in the sense required by this definition.

It must then be assumed that all inherited variations are blastogenic and arise in the germ plasm. One of the means for producing variations in this way, namely,

sexual reproduction, has already been referred to. Weismann also assumes that the biophors and determinants are subject to continual minute fluctuations in their composition, thus tending to produce minute changes in the cells and organs of the adult. But the germ plasm consists of many Ids, and an inherited variation will be produced if many of the determinants for the same part vary in the same manner. These variations in the germ plasm are referred largely to local causes, such as slight differences in the nutrition of the germ cell. Before Weismann's time it was universally supposed that acquired characters were inherited, and it may be imagined that biologists were not ready to give up the idea that none of the effects of external influences, which certainly produce marked somatic changes, are inherited; indeed, the subject cannot yet be regarded as decided. During the last three or four years there has been a controversy in the *Contemporary Review* between Herbert Spencer, who upholds Lamarck's principle, and Weismann. In one respect this controversy has been disappointing, for each has rather been trying to show the absurdity of his opponent's views, rather than bringing forward new facts in support of his own theory.

Professor Weismann's challenge to his opponents to prove the inheritance of mutilations seems hardly fair, for even Darwin, who certainly believed in the transmission of the effects of use and disuse, saw that according to his theory of pangenisis the ovum would still contain gemmules derived from the ancestors, which would be able to restore this part in the offspring. In an article in the *Contemporary Review* during the present year, Weismann appears almost to admit that the somatogenic variations may in some indirect way affect the germ plasm.

It is very easy on this point to argue in a circle, to assume that all new characters which are inherited are blastogenic, or arise in the germ plasm, and from this assumption to prove that somatogenic variations are not inherited, thus making the facts agree with the theory, instead of the theory to explain the facts.

If the transmission of somatogenic acquired characters be believed, it becomes necessary to modify our conception of the germ plasm, though it need not necessarily lead us to deny its existence; the essential separation of body cells and reproductive cells must, however, be denied, and there must exist some mechanism connecting these groups of cells which enables changes produced by external influences on the body, to influence the constitution of the germ plasm. The continuity of the germ plasm of the parent with that of the offspring can only be made out in a few cases. The only instance where this really occurs is in some insects (Diptera), where the first segmentation of the egg cell actually does give rise to a cell which gives rise to the future reproductive cells, and a cell which gives rise to all the somatic cells. In a few insects, too, the cells which give rise to reproductive cells may be distinguished after about six divisions of the ovum. In most cases, however—for example, in vertebrates—the germ cells are separated off at a very late period in development, and in many animals—for example, where there is alternation of generations; for instance, the hydroids—the reproductive cells are not formed in the individual which has developed from the ovum at all, but in another individual which has developed from the first by budding. Weismann lays much stress on the structure of the interesting colonial Protozoon Volvox, in which there certainly does appear to be a division of the cells into two kinds; one series, which are locomotor and nutritive, and may be compared to somatic cells, the others being reproductive cells. Volvox does certainly bear a resemblance to a multicellular animal; but it is really difficult to see how multicellular animals could have arisen from such a form, judging from known species. There are also colonial protozoa which almost exactly resemble volvox, only they have not this differentiation in their cells, all of which are able to form a fresh colony in the same way as the reproductive cells of volvox. These facts lead us to regard Volvox as a highly specialised side branch in the genealogical tree of evolution. There is, however, another possible method of transition between unicellular and multicellular animals, through some such forms as the remarkable animals the Myxomycetes, which are large masses of protoplasm, and which may measure several inches across; they contain many nuclei, and may be regarded as multicellulated protozoa, since they are not divided up into separate cells. These animals reproduce by means of spores, which may be formed in a very short time, at almost any part of the protoplasmic mass. The transition from such an animal to the simple turbellarian worms appears quite easy. The simplest of these worms is an animal Haplodisus which consists of a multinucleated mass of protoplasm, not covered by a layer of ectodermal cells but only with a cuticle, beneath which certain muscular bands are differentiated. There is no alimentary canal, but through an aperture in the cuticle processes from the internal protoplasm are sent out, apparently of the same nature as the pseudopodia of the amœba. Within the protoplasmic mass reproductive cells become differentiated, but these cannot be regarded as separated from this protoplasm, until they are fully ripe. The only thing which sharply marks off the animal from the protozoa and settles it to be a tubellarian is the character of its reproductive organs. From this simple animal to the highest tubellarians there is a perfect series of intermediate forms, and the highest tubellarians present interesting approximations to other groups of animals.

According to such a view as the above, the reproductive cells are regarded as forming, until maturity, part of a protoplasmic reticulum, there being no sharp division between somatic and reproductive cells till the latter are fully ripe and ready to be shed. The separation of the reproductive cells would thus be somewhat analogous to the internal gemmation seen in some protozoa.

These views are supported by the researches of Segdwick on the development of peripatus, which,

again, is a primitive form, showing relations to several other classes of animals. Sedgwick found that in the development of this animal at the close of segmentation, that the ovum had not divided into cells sharply separated off from one another, but that the separation was slight, there being really a reticulum of nucleated protoplasm.

There are also many facts which tend to prove that even the highest animals and plants are not divided up into cells which are sharply separated off from one another. Thus, it was proved in some plants that in many of the tissues, though apparently divided up into distinct and separate cells, yet special staining revealed fine processes of protoplasm connecting adjacent cells through very fine walls in the cell wall. Indeed, this would seem to be a general phenomenon in plants. In the higher animals the same principle has also been proved to hold good. Thus, cartilage cells, connective tissue cells, epidermal cells, and others have proved to be connected by fine branching processes. Indeed, the body of an adult mammal might almost be regarded as a protoplasmic reticulum more or less incompletely subdivided into cells. The cells of the blood and ripe reproductive cells, however, appear to be exceptions to this; the blood-cells may, however, certainly be regarded as having been continuous with other connective tissue cells at an earlier period in their existence. This is very probably also the case with the reproductive cells, the egg cell being connected with the follicle cells by minute protoplasmic processes passing through the zona radiata, and thus entering in relation with the cells of the body as a whole.

If these facts can be regarded as general—which is by no means proved at present—it can be understood how external influences acting on the body can influence the germ cells; for if the body can be regarded as consisting of a continuous protoplasmic reticulum, we can understand how a change in the constitution of the protoplasm of one part of the body could be transmitted to a remote part.

I should like now just to mention a theory of Heredity which has lately found much support in America. This theory does not assume that the future parts of an animal are represented by minute particles, such as is required according to the theories which we have previously considered. It gives to the ovum a definite molecular structure, and regards development as due to the action on the ovum of certain forces, external and internal. The chief internal force is regarded as metabolism, while the action of this force is modified by external forces, such as light, heat, nutrition, etc. There can be no doubt that such external forces have the power of greatly influencing the development of the embryo. According to this view, the complicated division of the nucleus is looked on not as the cause of development, but rather as the result of the action of these forces.

To sum the matter up, it must be confessed that the subject cannot as yet be regarded as decided; though there can be no doubt that Professor Weismann's views afford the most complete and most suggestive explanations of the facts which we have considered.

And now, in conclusion, I have to thank the meeting for the indulgence with which this paper has been received, and to trust that the discussion to follow will make amends for its numerous deficiencies.

Winter Walks.

I propose, in the short series of articles which I am from time to time going to put before the readers of this journal, to give suggestions for passing a pleasant Saturday or Sunday in some of the lovely districts near London. I believe the assistance, which I shall be able to give, will be acceptable to many—both to students and to nurses; therefore, I make bold to put forth my plan to the readers of this Gazette.

I was particularly struck with the fact, that during my long sojourn at Guy's, I found, that with the exception of going "up west," or going "up the river," the majority of men with whom I was in contact had never carried their explorations further. One gentleman, indeed, who had possibly never been beyond Kennington, since his arrival from Wales, made the astounding remark that London was a very ill-situated town as regards the beauty of its surroundings. Now, I trust that those who may be adventurous enough to follow out some of the little excursions that I shall suggest, will agree with me, an old Londoner, that the metropolis is within easy reach of some of the most picturesque scenery in Great Britain, and for the most part surrounded by country which is, of its kind, quite perfect.

I shall, in dealing with each district that I describe, consider the majority; therefore I shall not advise long and tedious walks, and I shall give such trains as can be caught without encroaching too much upon the hours of sleep. In every case I shall, at the risk of being thought vulgar, give the cost of each excursion, and confine my attention to those districts that I know thoroughly. Again, considering the majority, to which, in fact, I myself belong, I shall consider that everybody will go third-class, and that comfort is to be studied as regards the hotels and other resting places. I shall describe each route from the personal standpoint, that being less tedious than a mere impersonal description; perhaps I may at times touch on details, trifling in themselves, but which, it is my firm conviction, go so much to enhance our pleasures. Throughout I shall try and resemble the guide books as little as possible, for, again, I am at one with the majority in finding such literature, though perhaps useful, too dull for words to express, and unsuitable besides for a magazine. I may, however, state that Stanford's Guides (published at two shillings) are handy little books for the pocket, and contain fairly good maps.

In my first article I shall describe a journey I made to Godstone in good and congenial company.

REDHILL TO GODSTONE.

"Afoot and light-hearted I take the open road,
Healthy, free, the world before me,
The long brown path before me leading wherever I choose.

"Henceforth I ask not good fortune, I myself am good fortune,
Henceforth I whimper no more, postpone no more, need nothing;
Done with indoor complaints, libraries, querulous criticisms,
Strong and content I travel the open road."

WHITMAN.

Perhaps the individual who thinks that there is no scenery worth seeing nearer London than Cornwall or Devon, will not agree with me when I say that, to my way of thinking, late autumn, aye, and winter itself, are *par excellence* the times for a country tramp. In summer the highways are dusty, overrun with cyclists, and the heat makes one ill-tempered and footsore.

The day we chose for our Godstone trip was one of those fine warm days late in October, when all nature looks mellow and jolly. We caught the 9.2 a.m. train from London Bridge Station, leaving the Borough, and the Hospital it contains, to all the delights of a stuffy, foggy Sunday. The train went badly at first, evidently with the idea of acquiring that becoming *soupçon* of unpunctuality which the fashion of the Brighton Railway demands. As we got down the line, the fog lifted and the sun blazed out golden and bonny. Redhill was reached some fifty minutes after leaving the Borough. On alighting, the air was clear, the sun brilliant, and we were soon tramping along the hard gravelly road which skirted the side of a large valley, our path rising and falling with pleasant undulations.

The hills on the other side of the valley, wooded in part, their faces carved with numerous chalk-pits, presented a fine spectacle, while between them and us were pleasant meadows and cosy-looking houses dotted about. Our road led us along pleasing plantations with a rich variety of foliage, the black-green Scotch firs contrasting with their berry-brown sisters, rustling and drooping their leaves to the passing breeze. We were too enchanted to talk one to the other, but stepped briskly forward, absorbed in the delights that Mother Nature had set before us; and so, ever forward, till we reached Nutfield—a sweet English village—where, sad to say, the builder had been hard at work mixing the new with the old; fortunately, however, only mixing and not destroying.

Nutfield past, the valley widened out, and the road gently sank, giving us further glimpses of green and fresh-looking pastures. Presently we found ourselves approaching Bletchingly, one of the quaintest, oldest-fashioned of Surrey villages, famed in the old days as a Parliamentary borough and just such a one as Hogarth would like to have had as a setting of one of his grotesque election scenes. No wonder that in 1832, the "great and the wise" considered old England in her death throes when the Whigs disenfranchised such boroughs as Bletchingly! The quaint sign of a "White Hart," in true heraldic splendour, hanging from a finely-wrought iron setting, proclaimed that refreshment could be obtained for man and beast; soon we were ensconced in the snug ingle-nook by the cracking logs, and passing the compliments of the morning with our white-bearded, ruddy-cheeked host, who seemed to demonstrate the contention of the philosopher, that the greatest happiness, and the true wisdom of life are to be found in the country, and not in the grimy towns.

We had time on our hands, so we strolled round the village, admiring the quaintly-timbered houses and the narrow middle-row. We visited the church, where the hand of the destroyer was visible in its restoration; nevertheless it remained a pretty village building, approached between two magnificent yew-trees, standing like sentinels, one on each side of the gate.

Our road on to Godstone, still up and down, grew even more charming as we approached that village, with its triangular green common, its duck-pond, and its beautiful trees. Here we are going to take our dinner in one of the most picturesque inns in the South of England. This inn, too, is a "White Hart," and like most "White Harts," was built in the reign of Richard the Second—being given the King's device as a sign. This "White Hart" is, however, not known as such now, but is more familiar as "The Clayton Arms." Most of the house appears to be of the Elizabethan character, and presents a pleasant example of the inn of the olden time. We pass under the great arch into the court-yard with its many-timbered rambling buildings, to find the genial host, who reminds us of the dinner hour! Mr. Jell is proud of his inn, as indeed he should be, and takes us through the ample chambers, wealthy in old engravings, Chippendale cabinets, high-backed chairs, carved oak cabinets, ormolu mirrors, and other treasures equally delightful. A delicious odour pervades the house, that odour only produced in the country, where purity mingles with maturity. A well-cooked dinner was served in a wonderful oak-roofed banqueting-hall, and Mr. Jell dispensed the good cheer in the old-fashioned way, sitting with his family at the table with his guests. Dinner finished, we took our leisure in the smoking-room; like the other rooms, garnished with old china and stocked with grandfather-chairs. Before the day darkened we decided to climb Tilburstow Hill, passed up to the left of a wonderful fir forest ablaze in the setting sun, and enjoyed at the top the wide panorama spread before us. Having retraced our steps to our old inn, we spied this legend, which we had overlooked on our arrival:—

YE OLDE INNE,
Built in the reign of
RICHARD THE SECOND (1378),
Rebuilt in that of good
QUEEN BESS,
And often honoured by the presence of
QUEEN VICTORIA.

On enquiry, we found that Her Majesty, before the days of railways, used to choose this route when she went to the South Coast, and used to delight the villagers by pulling up at their old inn.

We then started away, as the day was waning, for the railway station, which lies some three miles away, at the village of Oxted. Our route took us past Godstone Church, and we paused to admire the fine old Norman doorway, with the curiously wrought hinges of the door. The situation of the church is admirable, and its interior is simple and good. Hard by stand some modern almshouses, built in the Elizabethan fashion, and heavily timbered with old oak, the design in excellent architecture and well worth seeing. We took the path *through* the churchyard, but first stopped to look down the road, which dips in the twilight, with great trees meeting and interlacing overhead. Our path soon brought us into the main road, which, after numerous hills and dales, brought us in sight of the lights of Oxted. We had not time to linger in the quaint, narrow street, and soon found ourselves in the bustle of a village railway station, thronged with villagers; white-faced Londoners, with impossible bunches of chrysanthemums; cockney youths, with country spoils—bags of acorns, boughs of trees—in fact, with anything that can be torn off and brought away; some had evidently been making good their time with some country wenches, to whom, no doubt, they seemed smart fellows enough, for they were laughing and indulging in love thumps *sui generis*.

The train now came along, we took our seats, and were soon being hurried back to town after having had a right pleasant and exhilarating excursion.

Expenses:—	s.	d.
Train to Redhill	1	8
White Hart (Bletchingly)	0	2
Dinner (Clayton Arms)	2	6
Train from Oxted	1	8
	6	0

Distance from Redhill to Godstone about four miles.
Distance from Godstone to Oxted about three miles.
Train from London Bridge (Sunday) 9.2 a.m.
Trains from Oxted, 5.34 p.m., 8.14 p.m.

A. PERCY ALLAN.

The Lock Hospital.

The following extract from Manning and Bray's "History of Surrey," vol. III., page 634, appears to explain the much discussed origin of the term "Lock Hospital":—

"THE LOCKE, OR LOKE HOSPITAL.

"At the south-east corner of Kent Street there was an Hospital for poor leprous persons, called the Lock or Le Lokés, without St. George's Bar, in Southwark. John Pope by his will, dated 1437, gave to the governors of it an annual rent of 6s. 8d. to the reparation and maintenance of the said house of lepers for ever. It came to be under the care of the Governors of St. Bartholomew's Hospital. There was a chapel, on the door of which, in Aubrey's time, was the following fragment of an inscription:—'M.B. This chapell is built to the honour of God, and to the use of the poore —— people harboured —— 1636.' This M.B. is said to be designed for M. Bond, a rich citizen of London, who gave £100 towards the building of this chapel. Stow says that he had not been able to discover the foundation of it, but it existed in the time of Edward II. There was a chapel in it. Tanner says it was dedicated to St. Leonard. It belonged to, and was long under the care of St. Bartholomew's Hospital, from whence patients were sent to it; but it has not been used for that purpose for the last fifty or sixty years, and has been let out in tenements. It is now pulled down; part of the ground is laid into the new road, which was formed in 1809 from the High Street in the Borough to the Dover Road, running parallel with Kent Street.* The remainder is let, or to be let, on building leases.

"It is in fact in the parish of Newington. There was at this place a stream, or open sewer, which was called The Lock; the tide came up so far, and horses used to be watered in it. This divided the parishes of St. George and Newington, and the site of the Lock is on the Newington side. This stream is laid down on Rocque's large map of Surrey, but is now arched over."

J. H. G.

Sport.

Association Football.

GUY'S v. BEXLEY.

Played at Honor Oak Park, on Saturday, November 23rd, resulting in a win for Guy's by three goals (Humphrey two, Thornely one) to nil. The weather was very unfavourable for football, as there was a very high wind, while the recent heavy rains had made the ground soft and slippery, rendering good play very difficult, and accurate passing an impossibility. During the first halfplay was very even, but we managed to score a goal and so crossed over, leading by one goal to love.

The second half went greatly in our favour, but we only managed to add two more to our opponents' one. A pleasant but scrambling game thus ended as stated above. Team:—

Guy's.—H. M. S. Barker (goal); E. A. Longhurst and G. Marshall (backs); H. A. Higgens, F. E. Walker and B. Hall (halves); L. Humphrey, M. Thornely, G. Ford, W. G. Palmer and P. S. Mandy (forwards).

* Now Tabard Street.

SURREY CUP TIE—2ND ROUND.

GUY'S v. REIGATE PRIORY.

Played at Reigate, before a large crowd, on November 30th, resulting in a somewhat lucky victory for the home team by four goals to three.

Guy's kicked off down the slope with the wind against them. The seven minutes' walk from the station had evidently proved too much for our forwards, as during the first quarter of an hour Reigate pressed and finally scored; but after this reverse our men worked hard, as the result—three goals before half-time—testified. Just before the interval, "hands" was given against us close to our goal, and from the kick Barker unluckily fisted into his own goal. At half-time we led by three to two.

On crossing over, Reigate pressed hard and soon equalised after some good all-round play. This put our men on their mettle, and they worked hard, but were extremely unfortunate in not scoring on two or three occasions. About ten minutes from time Reigate notched the winning point, and, though our men strained every nerve, time was called without further addition. Hall, Longhurst, and Barker showed up best for us. Several Guy's men, including some prominent members of past teams, went down to encourage the players, but even their presence was not sufficient to give us the victory. Team:—

GUY'S.—H. M. S. Barker (goal); E. A. Longhurst and G. Marshall (backs); R. W. Hall, F. E. Walker, H. A. Higgens (half-backs); P. S. Mandy, W. G. Palmer, G. Ford, M. H. Thorneley and L. Humphrey (forwards).

GUY'S 2ND XI. v. ST. MARY'S 2ND XI.

Played at Wimbledon on Wednesday, November 27th, and resulted in a win for Guy's by two goals to one. Walker kicked both the goals—the first one after a great deal of passing in front of the posts, the second one after having dribbled the ball for nearly half the length of the ground. The game throughout was very slow, through the ground being so heavy and the ball very slippery. Team:—

GUY'S.—A. R. Thomas (goal); J. Matthews, W. H. M. Smith (backs); R. W. B. Hall, M. Thorneley, H. A. Higgens (half-backs); R. G. Edey, A. A. Miller, F. E. Walker, A. Pearson, L. Humphrey (forwards).

Rugby Football.

GUY'S v. CATFORD BRIDGE.

Our special correspondent had written a full and highly interesting report of this match. Unfortunately this has disappeared, having been, it is thought, purloined by some time-pressed Guyite. We may, however, say that the match was played on November 23rd, and ended in a draw, nothing being scored.

GUY'S v. LENNOX.

This match was played at Dulwich on Saturday, November 30th. Guy's had the best of the game during the first half, but failed to score, whilst a pretty piece of combined play amongst the Lennox backs enabled them to obtain a try behind the posts, which was converted. On changing ends, Lennox had much the best of the play all through, though they failed to score, and the match ended in a win for Lennox by one goal to nil. Guy's went to pieces badly in the second half of the game; the forwards played in a half-hearted manner, and more than one of them was not doing his full share of work in the scrum. The backs were nearly as bad as the forwards, though one exception was found in Muriel, who played a good game all through at back. Team:—

GUY'S.—G. B. Muriel (back); F. L. Rae, F. C. Wetherell, K. B. Alexander, F. Sime (three-quarter backs); R. Mathias, J. N. Gardiner (half-backs); C. R. Nicholson, P. A. Dykes, W. P. Gwynn, P. D. Hunter, H. G. Rashleigh, H. V. Bagshawe, F. G. Gibson, W Tyson (forwards).

GUY'S 1ST XV. v. EAST SHEEN.

Played at Honor Oak on December 4th, the result being a win for Guy's. Our opponents started the game, playing against the wind. We began to press from the first, and after fifteen minutes' play Gardiner dropped a neat goal. Soon after this T. Morgan got in behind the posts, and Gwynn converted. In five minutes Sime again got in, but the place-kick failed. Half-time was called, with the score:—

Guy's Hospital ... ... 12 points.
East Sheen ... ... nil.

On restarting, play was of a more even description. We got well up to their line on several occasions, but could not manage to score. The final result being:—

Guy's Hospital ... ... 12 points.
East Sheen ... ... nil.

Team:—

GUY'S.—G. B. Muriel (back); F. L. Rae, T. Morgan, F. D. S. Jackson, F. Sime (three-quarter backs); J. N. Gardiner, F. E. Walker (half-backs); E. G. Goddard, P. A. Dykes, W. P. Gwynn, H. G. Rashleigh, P. D. Hunter, F. G. Gibson, M. D. Wood, W. Tyson (forwards).

GUY'S 2ND XV. v. UPPER CLAPTON "A."

This match was played at Tottenham, on Saturday, November 23rd. Having lost the toss, we kicked off against a gale of wind. They were in our twenty-five nearly the whole of the first half, but nothing was scored.

Having crossed over, the Guy's forwards pushed their more numerous and heavier opponents all over the place and from a scrum in their twenty-five, Featherstone dribbled over and scored; T. Morgan converting. This was the only point scored. Owing to the late start, the game had to be discontinued owing to the darkness, there still being about ten minutes to time.

Guy's played one short all through. The forwards tackled and dribbled splendidly, the most conspicuous being Featherstone, Mottram and Watson; Rowe and Walling did very well at half, and Dowsett was the best of the three-quarters. Team:—

Guy's.—Manson (back); E. C. Dowsett, A. C. Ransford, R. I. Pritchard, T. Morgan (three-quarter backs) H. W. Walling and E. R. Rowe (half-backs); G. N. Mottram, F. R. Featherstone, N. Williams, C. Watson, E. I. Spriggs, H. H. Bignold, M. D. Wood (forwards).

GUY'S 2nd XV. v. ST. BARTHOLOMEW'S 2nd XV.

This match was played at Honor Oak Park on Saturday, November 30th, and ended in a win for Guy's by one goal to nil.

We kicked off, and the ball was returned to the centre, where numerous scrums were formed; the ball, being very greasy, was difficult to handle, and so the halves had very few chances to get it away. About half-way through the first half Garland was badly hurt, and had to retire, which necessitated Kinsey-Morgan coming up to half, Ransford going centre three-quarters, and N. Williams full-back. Our forwards, being one short, bucked up, and played with rare dash. Bart.'s centre three-quarters, Hodgkins, had hard lines in not scoring, just losing the ball on the line. The teams crossed over with nothing scored, although when the whistle went Guy's were pressing them very hard.

During the second half our misfortunes were not ended. Featherstone, on being tackled, hurt his knee badly, and had to retire. The tackling on our side now became very keen, especially amongst the forwards. From a scrum near their line Walling, getting the ball, feigned to pass, dodged over and scored, T. Morgan converting. Final score, Guy's one goal; Bart.'s nil. The Guy's forwards played a splendid game, Cohen and Mottram being perhaps the best, but the tackling of each one was very keen and sure.

Kinsey-Morgan and Walling at half-back played very well together and gave their three-quarters plenty of work. Dowsett played well and made some very pretty runs. Ransford tackled well. Williams, at back, had very little to do. Team:—

Guy's.—A. C. Ransford (back); E. C. Dowsett, Kinsey-Morgan, H. P. Barrow and T. Morgan (three-quarters); J. O. Garland and H. W. Walling (half-backs); E. Cohen, M. D. Wood, G. N. Mottram, E. R. Rowe, N. Williams, F. R. Featherstone, C. Watson and H. H. Bignold (forwards).

United Hospitals' Football Club.

A meeting of the United Hospitals' Football Club was held at King's College Hospital, on November 28th. The election of officers for next year was first proceeded with: A. Allport was re-elected president, and K. B. Alexander was elected on to the selection committee. The draw for the Cup ties then took place, and resulted as follows:—

First Round.

A. Charing Cross v. St. Bartholomew's, January 27th.
B. Guy's v. Middlesex, January 28th.
C. St. Thomas's v. London, January 30th.

Byes—University, St. George's, St. Mary's, King's, and Westminster.

Second Round.

D. Winner of A. v. Winner of B., February 10th.
E. Winner of C. v University, February 11th.
F. St. George's v. St. Mary's, February 13th.
G. Westminster v. King's, February 14th.

Semi-finals.

H. Winner of D. v. Winner of E., February 25th.
I. Winner of F. v. Winner of G., February 27th.

Final.

Winner of H. v. Winner of I., March 5th.

Appointments.

Browning, B., L.R.C.P. Lond., M.R.C.S., D.P.H. R.C.P. Edin., has been reappointed Medical Officer of Health by the Weymouth and Melcombe Regis Urban District Council.

Hall, F. W., M.D., M.S. Lond., M.R.C.P., L.R.C.S., has been appointed Honorary Assistant Physician to the Sydney Hospital, New South Wales.

Hayward, J. W., M.R.C.S., has been appointed Medical Officer to the Whitstable Urban District Council.

Keiffenheim-Trubridge, L. W. A., M.D., B.S. Durh., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health, for the Hoo Rural Sanitary District, *vice* Packman.

Loveday, W. D., L.R.C.P. Lond., M.R.C.S., has been appointed Deputy Medical Officer for the Second Sanitary District of the Ware Union.

Manning, Guy E., L.R.C.P. Lond., M.R.C.S., has been appointed Resident House-Physician to the Sunderland Infirmary.

Packer, Harry D., M.R.C.S. Eng., L.R.C.P. Lond., has been appointed Resident Medical Officer to the East Riding Lunatic Asylum, Beverley, Yorkshire.

Sharp, Hugh C., B.A., M.B. Cantab, has been appointed Honorary Medical Officer to the Royal Cornwall Infirmary, Truro.

Strover, H. C., L.S.A., L.A.H. Dub., has been appointed Medical Officer for the Tempsford District of the Biggleswade Union.

Birth.

BATES.—On November 21st, at Church Road, Upper Norwood, the wife of J. Curling Bates, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

Death.

LANE.—On November 14th, at Brook Street House, Bath, Benjamin Hugh Lane, M.R.C.S., L.R.C.P. Edin., younger son of Brigade-Surgeon B. Lane, late A.M.S., of Priory Street, Cheltenham.

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Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold, will be One Shilling and Sixpence.

Guy's Hospital Gazette.

DECEMBER 21, 1895.

Say you the stories are told,—all told?
Call you all sentiments old,—too old?
Yet tell us the stories all through once more,
Speak the old sentiments treasured of yore!
—*Christmas Effort.*

A Merry Christmas and a Happy New Year. The old words will serve us, and our readers will wish for none other. They are of the heart, hearty. Our contemporaries, of course, have printed the words months ago; but our greetings are none the less genuine because they appear at the right time. We have urged this before. The Gazette Christmas Number turns up at Christmastide, and we make no apologies to this Age of the Premature.

Since Christmas was discovered (to literature) by the late Charles Dickens, there has been only one way of writing about it: so we will not write about it. It shall be to this article merely as the onion to the salad—a flavour, not a visible component. We have removed an adventitious and unnecessary sprig of holly from the seat of the editorial chair, and we have sat down to write common sense.

But talking of holly reminds us of a subject for seasonable congratulations. We mean the fact that we have still some wards left to decorate this Christmas. Now some people (who ought to know better) have been talking lately as though this would not by any means be a foregone conclusion. The wards are intact, however, and "Sustentation" is in the air. Yet a little while, indeed, and there shall be more space for the holly than is found this year. We have Sustentated; we are Sustentating; we shall and will Sustentate. That conjugation is our first Christmas sentiment.

Having first got (and kept) your ward, then decorate it. Christmas decorations make good copy for the Gazette. All hospital men have pleasant recollections about them, and the cheap cynic is warned by most to keep off the green-stuff. Yes; they have pleasant recollections; there was a nurse once—but that is another story! If you are by profession a surgical ward clerk, it is during decoration time that you first find yourself a person of some importance. If you are tall, and can reach the top corners, some ladies in the ward will know you quite well who formerly had ignored your very existence. On the other hand, if your trade be that of house-physician, or of house-surgeon, you find the decorations make an excellent subject for conversation when going round; and you discover in them an outlet for the money which has accumulated during a period of Free Board. For the rest, it is so pleasant to see the pride the Sisters take in each other's wards. This latter enthusiasm, it is true, raises for the Gazette a little difficulty. In describing the decorations in our next issue we shall, as ever, find a difficulty in choosing exactly the right words, because each Sister is so much hurt if we don't do justice to her sister Sisters. You know what we mean.

But this is all by the way. The decorations we really wanted to speak about are durable things in themselves, and still more permanent in what they imply. We mean the mural tablets which are beginning to appear here and there in the wards, setting forth that the beds beneath are endowed in perpetuity. Votive, commemorative, or merely recording a philanthropic impulse, these tablets are, we hope, going to be very numerous on our walls. A bed in Accident commemorates the death of Mr. Henry Cohen: two others will shortly become sacred to the memory of Arthur Durham—an evergreen memory, surely—and other tablets are to follow. Among them we hope will be one to associate a bed for ever with the revered

name of John Keats. Endowed hospital beds are an ingenious outlet for altruism, and there is no need for us to lose dear friends as an excuse for them: it is only necessary to stimulate the philanthropic impulse referred to above. All of us go at times to where money is to be found, and if, as is probable, we cannot get it for ourselves, let us get it for endowed beds. Let us remind our rich patients that if they cannot hope for a monument in Westminster Abbey they can have their names, with at least one good deed attached, recorded in perennial brass on the walls of Guy's Hospital. At least twenty thousand people in the United Kingdom could spare the sum of a thousand pounds without missing it. Roughly speaking, a twentieth of that number are grateful patients of Guy's men; and if only half of this fraction would have a tablet put up the Sustentation problem would cease to exist: Guy's would become a National Gallery of the Records of Benevolence, a Record Office of Altruism, and every ward would teem with human interest—there's a picture for you! We will put up these decorations next Christmas.

We wish after all that we could mingle Christmas and the Sustentation Fund, as Dickens would have done, were he alive and writing for us. He would have made much of the niggers, for instance. There was always something of the heroic about this annual face-blacking business. But this year the heroism is pronounced. Fancy the average self-conscious young man consenting to appear before large London and suburban audiences in the garb of a professional Mohawk, in order to swell the funds of his hospital, and advertise its wants; submitting, moreover, to weeks of hard training in order to make himself efficient in the rôle. The "Dis-Guysed" Minstrels are jolly good fellows, and we wish them every success in their public performances; the Hospital will owe much to this development of an old Christmas institution. There are other organisations beside our own particular minstrels who are cozening money out of the public for us by the good old plan of ministering to its amusements. Notably, the "Anomalies" Dramatic Club, whose coming performance has been before referred to in our columns. We mention this with gratitude, and we mention it, too, because we believe the good example will be followed by kindred clubs when our need is made known to them. The Entertainer is a power in the land, and all who want charity do well to gain his ear.

Enough of these hints; we do not want to write entirely of our wants here, though to refer to them is the best of common sense just now. Sustentation is going along very well, and, altogether, if we take a survey of things at the close of the year of Grace, 1895, there is much to justify a little Christmas optimism. We have maintained throughout the year an excellent standard of success at examinations. At the London University we proved ourselves once more *facile princeps*.

And if we prize this distinction, we may rejoice at an event which will mark this Christmas of 1895; we mean the building of our new Physiological Laboratories. The first steps are being taken even as we go to press. It is not, perhaps, quite universally recognised that the great value of an efficient scientific department to any Medical School lies, not alone in its effect on the results of the preliminary examinations, but still more in the fact that it attracts the best men to the school. Even now our entry of London University men is large as compared with that of other schools; but when our physiology department is as efficient as the anatomical or chemical, we shall have better scientific opportunities than any school in London, and we shall recruit from the best men; for, naturally enough, your junior student is influenced more by what immediately concerns him than by questions more remote. Thus we believe the new laboratories will indirectly, as well as directly, raise the standard of clinical work done by students in the wards, and so improve our present high position as a clinical school.

If we are proud of our London University results, we have no reason to complain of what has happened at other examinations; the year's record has been a good one.

We heartily regret that so few men came to us from Oxford and Cambridge in the past year, but when we re-open the closed wards they will turn their faces towards the Boro' once more. Rumour says, indeed, that they will not wait for that; but this question hangs almost entirely on that other one, which we cannot for the life of us keep out of this article. It is Sustentation over again.

But we do not wish to do more than remind our readers that there are many lights upon the horizon. We have endeavoured to keep the editorial gasometer-tap well in hand, but it must be understood that the pressure is enormous.

Once more we offer our good wishes to all our readers, asking them to choose for a New Year's motto the word "Sustentation."

The Church of St. Marie Overie.

In our issue to-day we publish a reproduction of a sketch, by a well-known artist, of St. Saviour's Cathedral, Southwark (then called St. Marie Overie), with old London Bridge in the background, and Winchester House to the left.

To those who are not familiar with the legend of the foundation of St. Marie Overie, the following from the chronicles of London Bridge will be interesting.

Before the time of any London Bridge, a ferry plied across the river between Dowgate Dock and St. Saviour's Dock, both of which still exist under the same names; now the ferry master—one Awdrey—had a lovely daughter named Mary, of whom many knights became enamoured, both for her beauty, and that her father had become very rich: yet he was avaricious, covetous and miserly. Of course the fair Mary lost her heart to the poorest of the knights, but Awdrey père would not countenance the match, so the noble knight removed to another place, still guarding the memory of Mary.

Then one day the old man, devising a way to save a few meals—for at a time when death is in the house who can think upon eating and drinking—pretended that he was dead and laid himself out with a white sheet over him: yet his servants, hearing the news, stripped the larder, opened the casks and began to feast and sing. This was more than the old man could endure. He sprang up and rushed among them—they fled shrieking, taking him for a ghost, but one, bolder than the rest, banged the apparition over the head with the butt end of a broken oar, so that the would-be ghost became the thing he simulated.

The miser's fortune devolving on the daughter, she sent for her lover, who, when on his way, was thrown from his horse and killed; so the girl in her misfortune founded a convent of sisters at the south end of the ferry, and taking refuge in her own Foundation, retired from the world.

Old Stow says that afterwards, when in 1106 the convent had been converted into a convent of priests by William Pont de l'Archy and William Dauncy, knights, the priests built a bridge of wood over the river and kept it in repair until later; considering the expense of such repairs, there was, by the aid of the citizens using it, a bridge builded of stone. London Bridge is mentioned in the charter granted by the Conqueror to the monks of Westminster Abbey in 1067; but the earliest historical notice of it is its destruction in 1091, when it was swept away by the violence of the tide. After this, from fires and other reasons, the old bridge of wood was frequently re-built, until 1176, when the first bridge of stone—not finished till 1209—was commenced. The cost was defrayed by a general tax on wool, and so the popular saying arose that "London Bridge was built upon woolpacks." The architect, Peter, of Colechurch, died in 1205, and was buried in the chapel of Thomas à Becket, which surmounted the central pier of the bridge. This bridge, which is the one which, after frequent alterations and repairs is represented in our picture, consisted of twenty arches supported upon nineteen piers; the roadway was 926 feet long, 40 feet wide, and 60 feet above the river—the space was later much encroached upon by the building of dwelling houses. Between the chapel of St. Thomas à Becket mentioned above and the Southwark end, one of the arches was formed by a drawbridge, at the north end of which opening was a tower, built, according to Stow, in 1426, and on the front of this the heads of persons executed for high treason were stuck, till in the latter part of the 16th century the tower was replaced by a very singular edifice of wood, called Nonsuch House, which is said to have been constructed in Holland and brought over in pieces and set up entirely by the use of wooden pegs, no mortar or iron being used. When the old tower was taken down in 1577, the exposed heads were removed to the Tower over the South gate, or foot of the bridge, and that gate then received the name of the Traitors' Gate.*

Such is the bridge represented in our sketch, and which, founded in 1209, with many transformations and alterations from time to time, existed till 1832. Many times was it burnt down—first in 1212, when a fire sprang up in the church of St. Marie Overie, and was carried by the wind over the bridge. (Stow relates that over 3,000 persons perished miserably on this occasion.) Again, all the houses were destroyed in the great fire of 1666. Linstead placed the foundation of the convent of Marie Overie† as "long before the conquest," and the second endowment, as noted above, was for "canons regular." Gifford, the then Bishop of Winchester, built the

* The heads of the executed are seen over the South or Traitors' Gate in our illustration.

† St. Mary clearly refers to Mary Awdrey and not to the Mother of our Lord, as a special chapel (the Lady Chapel) is dedicated to her. Overie is derived from either "Over the Rhé" (Saxon = river), or, more probable "o' the Ferry."

splendid palace adjoining, known afterwards as Winchester House.

The Priory received no small damage from the Southwark fire of 1212, and after serious assaults from "the violence of the River Thames," the church was restored at the close of the 14th century, the poet Gower contributing the principal funds. His resting-place here is marked by a beautiful monument in the south transept of the church, whence it was moved from a part of the north aisle of the nave, called St. John's Chapel. In 1539, the Priory was dissolved, and Linstead, its prior, pensioned off. The palace was sacked by Wyatt's soldiery in 1554, and the library burned. In the year 1607, Edmund Shakspeare, player, the dramatist's brother, found his last resting-place in the church, and in 1625 the same register records the death and burial of "Mr." John Fletcher, the poet. In the churchyard Massinger lies, and near his grave the projecting transept with its beautiful windows is a restoration of the exquisite work discovered among the remains of Winchester Palace, and which doubtless lighted the large banquet hall seen in its pristine glory in the picture which it is partly the effort of these short notes to illustrate.

On Three Cases of Abdominal Disease.

CLINICAL LECTURE BY DR. PYE-SMITH.

Gentlemen,—The Clinical wards are at present full of interesting cases. There are five cases of typhlitis, two cases of tumour of the brain, and two cases of hemiplegia. Three cases of acute abdominal disease have proved fatal, and it is of them that I propose to-day to speak.

Case I.—Invagination.

In this condition, part of the gut is by its own violent peristalsis pushed inside the next (perhaps more or less paralysed) part, as you may push one part of the finger of a glove into the other. The first effect produced by the "plug" of invaginated bowel is that it acts like a foreign body—as a local irritant. Its walls next become congested from pressure on the mesenteric blood-vessels, and it soon obstructs the passage of fæces.

Thirdly, the pressure on the vessels increases by the swelling it produces until the plug becomes gangrenous and sloughs off.

Death may occur at any period, either from shock, from peritonitis, or from perforation.

This disease is most frequent in young children. More than two-thirds of the patients are under two years of age.

When invagination does occur in adults it usually affects the small intestine, and presents a different clinical form of disease. In the following remarks I shall confine myself to intussusception as it occurs in children.

Anatomical varieties.—In the great majority of cases the last portion of the small intestine pushes itself into the cæcum, and continues to push on until it has passed right round the colon and may be felt in the rectum. Indeed, cases have occurred in which the "plug" has been actually mistaken for prolapse of the rectum, and has been pushed back into its supposed place under this mistake. It has also, as I have seen, been mistaken for polypus of the rectum.

The commonest kind of invagination is called ileo-cæcal, and in it the valve always forms the "presenting" part. It is probably met with in eleven out of every twelve cases.

The next in frequency is the form in which one part of the small intestine pushes itself into another part. This was the case in the patient we are speaking of. A still less common form is that in which the ileum pushes itself through the ileo-cæcal valve into the large intestine, so that the ileum itself forms the presenting part. This is called the ileo-colic, or more distinctively, the valvular form. In another still rarer variety, a part of the large intestine pushes itself into another part. The rarest form of all is that in which the duodenum becomes invaginated, of which I show you a drawing.

Symptoms.—Most cases of invagination have a characteristic beginning. First there is a feeling of uneasiness, followed by pain and then by vomiting, hæmorrhage, and constipation, the latter being sometimes preceded by a loose motion. If you are called to see a child with these symptoms, then you may be almost sure that you have to deal with a case of intussusception. If you can feel the tumour through the abdominal wall or the rectum, then your diagnosis is certain.

Our patient was a boy, two years old; a healthy-looking child, and his mother says he was quite well until last Saturday (a week ago). On that day he was crying, apparently from pain in his stomach. She thought that he was suffering from constipation, and gave him a dose of castor oil, as she had done with good results in the case of her other children. It did not,

however, open the bowels or relieve the pain, and the child was still sick on Sunday. On Monday, the constipation and vomiting were accompanied by increased pain. On Tuesday evening the child was seen by a local doctor, who advised that he should be brought to the Hospital. This was only done the fifth day of the illness. On Wednesday afternoon, when admitted, the child was very ill, his face was pale, his eyes hollow, his feet and hands cold; his pulse was feeble, and breathing quick and shallow; in short, he was in a state of collapse. Taking into consideration the age of the patient, the history, and the fact that a tumour could be felt just above the situation of the cæcum, it was quite evident that this was a case of invagination.

The tumour is generally said to be sausage-shaped, and no doubt it is so when seen in the post-mortem room. But what you generally feel during life is a tumour which is not cylindrical enough to be termed sausage-shaped. What is more characteristic is the peculiar way in which it will sometimes move under your fingers.

In this case the tumour did not move, for adhesions had formed, tying it to the surrounding parts.

Having made our diagnosis of invagination, the next question is, what can be done? If you leave the child alone, death is almost certain. There is a bare chance that adhesions may form, and that the invaginated part may slough off, and the patient recover; the portion separated being passed per rectum. This is, however, a very rare occurrence. It is commoner probably in adults than in children; but in any case where operation is at all possible you would not be justified in waiting for such a forlorn hope as this.

The proper thing to do is to inflate the intestine through the rectum (an ordinary bellows will do very well), and thus to reduce the invagination. While air is being forced into the bowel you should keep your hand on the abdomen over the tumour. You first feel the whole abdomen swelling, and when the air reaches as far as the tumour, you may feel it disappear under your hand. If it comes back, inflate again, and even a third time. I know the case of a patient in whom the tumour was reduced three times by inflation, and he got well.

Some use large injections of water instead of air; but after experience of both, I think that inflation is safer and more efficient.

If you fail to reduce the invagination in this way, the best chance, and that a poor one, lies in operation.

In this case the patient had, unhappily, been left until the fifth day, so that adhesions had probably formed which would render inflation useless, and perhaps dangerous. I cannot give you very definite rules as to the time during which you should inflate, and when you should not attempt it. If you see a case within three days you should certainly inflate; if not until the fifth or sixth day, you must anxiously consider the patient's condition in each case and decide accordingly. After the sixth day I should not advise you to attempt this measure. In this case the child's condition was such that I decided against it.

He was put into a hot bath, and brandy was injected subcutaneously. When taken from the bath his legs and arms were bandaged up, so as to keep him warm and to accumulate the blood in the heart and great vessels of the trunk. Meantime the surgeon was sent for, and Mr. Lane agreed that inflation would be dangerous, and that the only chance lay in abdominal section. The intention was, not to reduce the invagination by manipulation, for we felt sure that adhesions had already formed, but to relieve the obstruction by making an artificial anus, and if the child improved to operate again and remove the tumour. Chloroform was given, and, as usual, favourably received. (Here let me advise you, while the patient is unconscious, to explore, and, if you think proper, to inflate, but not to attempt reduction of an invagination by taxis.) Mr. Lane cut down on the tumour we had felt, and the invaginated part was at once seen. The peritoneum was dull, and, on looking carefully, it was seen that the bowel had begun to slough at two places, and that it was nearly perforated.

The tumour being already out of the body, and in such an unhealthy state, it was thought the least dangerous course to remove it at once. It was accordingly resected and the two parts of the intestine joined together by a Murphy's button. Some brandy was given per rectum and morphia injected subcutaneously. The patient revived a little, but this improvement was only transient and he died two hours after the operation.

There is little doubt but that this child might have been saved if there had not been such delay in bringing him under proper observation.

On post-mortem examination, it was found that the silver button was quite secure. It

may be said that the disease was cured, though the patient died.

The invagination was about two and a half inches from the ileo-cæcal valve. A piece of ileum one and a half inch long had pushed into the succeeding piece of gut.

Case II.—Ruptured Hydatid.

The next case is a very remarkable one, but it was only in hospital a short time. The patient was a little girl, twelve years of age. She fell over a box and hurt her abdomen while playing. She was put into bed for a day or two and improved rapidly. During the next few days she was in apparently good health. Suddenly, however, the pain came on again, with vomiting and other signs of abdominal mischief. She was brought to the Hospital at once, in great pain and collapse, as if from perforation of an internal strangulated bowel, or of an ulcerated appendix cæci. The abdomen also contained fluid. On an exploratory incision being made, there escaped a large quantity of serum, deeply stained with bile, and a tumour was felt in the region of the liver, but the patient was too ill for anything further to be attempted, and died a few hours afterwards.

The character of the effusion in the peritoneum pointed plainly to the liver, and Dr. Taylor, who was present at the operation, thought the disease was either a ruptured gall-bladder or a ruptured hydatid cyst.

Autopsy.—We found two large hydatid cysts filling the greater part of the right lobe of the liver. One, the anterior and larger of the two, contained fluid which was very much bile-stained. It was clear now what had happened. When the child met with her accident, a hydatid cyst had ruptured into a space shut off by adhesions. The second attack of pain and vomiting was the result of rupture into the general peritoneal cavity.

Case III.—Ulcerative Colitis.

The third case is of considerable interest, partly because the disease is neither common nor well understood, and partly because we did not recognise it during life.

Of to-day's three cases, the first we diagnosed, the second we partly diagnosed, and the third we did not diagnose at all.

Another question we should ask after a patient's death is whether our prognosis was correct.

In the first two cases the prognosis was very bad; but in the following one I did not anticipate the patient's death until toward the close of his illness.

The patient was a man, 42 years of age, who had travelled in England and abroad. For two years he had been subject to attacks of pain in the right side, especially in the right iliac fossa. He had had several attacks of this kind, which lasted a few days at a time, with vomiting and constipation. The last doctor whom he consulted told him that he had typhlitis, or inflammation of the appendix. (The barbarous term appendicitis is quite needless. All cases of typhlitis begin in the appendix, which is part of the cæcum. Paratyphlitis and perityphlitis are only complications of this, never independent primary diseases. This was Dr. Wilks' teaching when I was a student, and all my subsequent experience confirms it. It is also the view taken in the last paper I have seen on the subject, one by Dr. Coupland).

Four days before admission, the patient again had pain in the abdomen; was constipated, and had some headache. His doctor advised him to have his appendix removed, and he came up to the Hospital with that object.

He was examined and put to bed, and after examination in bed, it seemed doubtful whether he had typhlitis at all. His temperature was 102° and pulse 116. There was slight distension of the abdomen and some pain in the iliac fossa. The spleen could be felt below the ribs, but there were no spots. From these symptoms the clinical assistant was inclined to think that he had enteric fever. The next day the bowels were open five times. The motions were loose and had an offensive odour, and are described in the report as "*typhoid*" stools. (I would advise you not to use this term, for there are no motions which enable you to say that the patient has typhoid fever, and I have repeatedly seen "typical pea-soup" stools when there was no pyrexia or other sign of enterica).

Spots were eagerly watched for, but they did not come. The abdomen, however, became more distended, and when I saw him the doubt still remained, and the question still appeared to lie between enterica and typhlitis: then, however, it was quite clear that whatever its origin, peritonitis was present, for there was great distension of the abdomen, the heart was pushed up, and the breathing considerably hampered. On percussion, a tympanitic note was obtained over the whole of the abdomen, and it was impossible either to feel the spleen or to ascertain the existence of a cæcal tumour. The symptoms in favour of the case being enteric fever were the raised temperature, the tumid abdomen, the enlarged spleen, and the diarrhœa with "pea-soup" stools.

One objection to this view was the repeated attacks of abdominal pain before the present illness. Again, the temperature chart was not at all typical of enteric fever, the temperature not going down in the morning as it should. Moreover, although the absence of rose spots is not conclusive, yet the more carefully you look for them, not only on the abdomen but on the chest, the flanks, and the back, the more seldom will you find them absent.

At the end of the second week of typhoid fever, patients are generally stupid or delirious, but this man was wakeful and intelligent. Typhoid patients are very pale and wasted, but this patient had a good colour, and had not lost much flesh with a fortnight's fever. I thought, on the whole, that the case was not enterica but peritonitis from typhlitis.

The next question was what could we do for our patient. An operation would have been exceedingly difficult with the extreme tympanitis present and dangerous from the presence of fever; besides the uncertainty of the diagnosis making its object also uncertain. The first indication was to relieve the extreme distension, which can be done by puncturing with a trocar and canula. I have done this more than once, following the lead of our late friend, Mr. Stocker, the apothecary to the Hospital—a man of great sagacity and vast experience. I have seen relief follow and have not seen evil results; but they *have* followed, and I do not advise your performing this operation except under very urgent conditions. Here I thought it justifiable. A small trocar was thrust into the bulging epigastrium, probably into the transverse colon, and some gas came out with such force as to blow out a match. The tension was relieved, but the improvement was transient, and the abdomen rapidly became distended again. The puncture was repeated after some hours, and with more lasting benefit. The patient, however, became delirious; he grew gradually weaker, and died after less than three weeks' illness.

Autopsy.—The spleen was enlarged. It was not soft as in enteric fever, and the ileum was free from disease; so also was the cæcum; so that both the alternative views considered during the patient's life proved incorrect. The disease was a much more obscure one—primary ulceration of the colon.

We found numerous ulcers extending from the cæcum to the rectum—some as large as a half-crown, some as small as a pea—not at all like either enteric or tuberculous ulcers, but closely resembling those of dysentery. In many places they were confluent, and large sloughs had formed, particularly in the transverse colon. There was a perforation also here, apparently made post-mortem in tearing though some adhesions.

Remarks.—Ulcerative colitis is not very uncommon, but its pathology is obscure. It was long ago described by Dr. Wilks, Dr. Moxon and by Dr. Dickinson as a complication of Bright's disease. Dr. Hale White, in our Reports for 1888, published a number of cases which he had collected with the view of finding some symptoms which would enable us to recognise the disease during life, but none of these are very distinctive. Pain shifting from one part of the abdomen to another, diarrhœa with passage of blood or mucus, a furred tongue, moderate pyrexia, moderate abdominal distension, occasional local tenderness and occasional vomiting, are the most commonly observed symptoms. Sometimes the tongue is furred, sometimes raw and red. The patient is often pale and sallow, and loses flesh. The cases I have seen have mostly occurred in the latter stages of Bright's disease. But I am familiar with a similar condition in children, which is sometimes called infantile dysentery, and usually yields to careful dieting with warmth to the abdomen and internal astringents, as chalk or bismuth, catechu, or logwood. Frequently I have seen ulceration of the colon unexpectedly found post-mortem.

I will conclude by giving you a list of the causes, so far as I know them, of ulceration of the colon.

1. *Tuberculous* ulceration.—This is always associated with, though sometimes more extensive than, ulceration of the ileum.
2. *Enteric* ulceration.—This is also secondary to ulceration of the ileum, but seems to determine the amount of diarrhœa.
3. *Cancerous* ulceration.
4. *Syphilitic* ulceration.—This rarely extends above the rectum.
5. *Toxic* ulceration.—Due to poisoning with irritants, like arsenic and mercury.
6. *Ulceration* from *distension* or impacted fæces. I have only seen this in the cæcum from stricture of the rectum.
7. Ulceration secondary to *strangulation.*
8. Ulceration due to *chronic follicular colitis.* In this case the ulcers are small and there is no sloughing.
9. *Ulcerative colitis of children.*
10. *Membranous colitis.*—Case now in Miriam.
11. True *dysenteric* ulceration. This is probably always due to the presence of the amœba

coli. It is closely associated with malaria and is now very seldom seen, except in men who have been in India or China, or other tropical countries. In former times it was common in England—(Cardinal Wolsey and Oliver Cromwell died of it).

12. Ulceration in course of *morbus Brightii.*

13. "Idiopathic" cases—*i.e.*, those which we do not know the cause—often complicating various chronic diseases, but occasionally, as in this case, appearing as an acute, primary and fatal disease.

Hospital News.

In the Medical Wards.

CLASSIFIED LIST OF CASES.

Circulatory System.

Mary	5, 23.	Mitral regurgitation.
	12.	Communication between aorta and pulmonary artery. Aortic and mitral regurgitation.
	13.	Mitral regurgitation. ? Pericarditis. Hæmorrhages.
	14.	Aortic and mitral regurgitation.
	17.	Pericarditis. Mitral regurgitation. Chorea.
	18, 35, 50.	Mitral stenosis and regurgitation.
Philip	2.	Aortic regurgitation and mitral stenosis.
	6.	Dilated heart.
	9.	Aortic stenosis and regurgitation.
	10.	Aortic regurgitation. Albuminuria.
Stephen	4.	Mitral regurgitation.
	9, 34.	Adherent pericardium.
	29, 33.	Aortic stenosis and regurgitation.

Nervous System.

Mary	2.	Peripheral neuritis.
	7.	Fits. Otorrhœa.
	8, 30, 32, 43, 46.	Chorea.
	28.	Pseudohypertrophic muscular paralysis.
	29.	Exopthalmic goître.
	41, 45.	Hemiplegia.
	49.	Paralysis agitans.
Philip	11.	Paraplegia. Myelitis.
	13.	Hereditary ataxy.
	20.	Locomotor ataxy.
	22.	Locomotor ataxy.
	25.	Cerebellar tumour.
	26.	Epileptiform convulsions.
Stephen	2, 8, 22, 26.	Hemiplegia.
	30, 39.	Chorea.
	36.	Locomotor ataxy.

Alimentary System and Abdomen.

Mary	11.	Gastric ulcer.
	15.	Marasmus.
	25.	Matting of intestine. Old pelvic peritonitis.
	27.	Jaundice. Enlarged liver.
	33.	Appendicitis.
Philip	14.	Jaundice. Carcinoma of liver.
	23.	Hæmatemesis. Gastric ulcer.
	27.	Cirrhosis of liver.
	31.	Appendicitis.
	34.	Carcinoma of pylorus.
Stephen	12.	Dilated stomach. Gastro-jejunostomy.
	13.	Epithelioma of œsophagus.
	16.	Appendicitis.

Typhoid Fever.

Mary	4, 9, 21, 24, 37, 38, 47.	

Genito-Urinary System.

Mary	1.	Uterine fibroids. Anæmia.
	6.	Tubal nephritis.
	19.	Chronic nephritis.
Philip	18.	Chronic tubal nephritis.
Stephen	6.	Tubal nephritis.
	25.	Subacute nephritis.
	27.	? Lardaceous nephritis.
	31.	Chronic tubal nephritis.
	38.	Lardaceous kidneys. Ozæna.

Respiratory System.

Philip	1, 3.	Pleuritic effusion.
	29.	Lymphadenoma. Mediastinal growth.
	32.	Hæmoptysis.

Miscellaneous.

Mary	3, 22.	Osteo-arthritis.
	36.	Lepra anæsthetica.
Philip	4.	Alcoholism.
	5, 7, 8.	Acute rheumatism.
	12.	Sarcoma.
	40.	Post-gonorrhœal arthritis.
Stephen	7.	Lymphadenoma.
	15.	Acute rheumatism.
	19.	Congenital syphilis.
	28.	Gonorrhœal rheumatism.
	40.	Pyrexia ? Cause ? Empyema ? Subdiaphragmatic abscess

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	11.	Loose body in knee; detachment of piece of cartilage and onset of symptoms three months after injury. ? Separation by necrosis.
	16.	Retained testicle and hydrocele. Cyst found projecting into cavity of tunica vaginalis. Origin doubtful. ? Serous. ? From organ of Giraldes.

Charity	6.	Cyst of breast.
	7.	Hæmorrhoids.
	10.	Ulnar paralysis, following division of nerve.
	17.	Lumbar abscess.
	20.	Strangulated femoral hernia. Kelotomy. (Mr. Jacobson).

Cases under Mr. Davies-Colley.

Luke	2.	Femoral hernia.
	3.	Varicose veins.
	5.	Ventral hernia. Radical cure.
	7.	Vesical calculus. Lithotrity.
	21.	Mastoid abscess.
Lydia	8.	Ulceration of leg. ? Syphlitic.
	Cot.	Swelling at upper end of femur. Exploration. Bone found expanded by tuberculous deposit.

Cases under Mr. Lucas.

Job	2.	Hydrocele of cord.
	16.	Traumatic stricture.
Lydia	14.	Chronic mastitis.
	Cot C.	Retained testis. Inguinal hernia.
Charity	1.	Otorrhœa. Pyæmia. Lateral sinus thrombosis.
	2.	Movable kidney. Sciatica.
	3.	Otorrhœa. Sub-dural abscess.
	Cot.	Congenital funicular inguinal hernia.
Accident	1.	Fractured internal condyle of humerus. Fractured olecranon.

Cases under Mr. Golding-Bird.

Accident	5.	Fractured astragalus.
	30.	Fractured os calcis.
Cornelius	4.	Fractured femur.
	20.	Fractured patella.
Martha	1.	Tuberculous ulcer of rectum.
	4.	Fissure of anus.
	6.	Papilloma on tongue. Excision.
	17.	Lipoma over head of tibia. Removal.
	19.	Sciatica.
Lazarus	—	Epithelioma linguæ.
	6.	Double otorrhœa.
	7.	Epithelioma of lips.
	11.	Tuberculous epididymitis.
	12.	Enlarged prostate.
	14.	Anthrax pustule.
	17.	Vesical calculus.
	21.	Femoral hernia. Radical cure by modification of Kocher's method for inguinal hernia.

Cases under Mr. Jacobson.

Naaman	4.	Strangulated inguinal hernia. Reduction with anæsthetic.
	21.	Perforating ulcer. Amputation of great-toe.
	23.	Appendicitis.

The S.E.R. Military Band and Minstrel Troupe.

It speaks well for the popularity of the above organisation that the Bermondsey Town Hall should have been crowded to its utmost on the night of the 9th instant, the occasion of their minstrel entertainment in aid of the Guy's Hospital Sustentation Fund. Not only was the performance of this energetic troupe fully appreciated by the enthusiastic audience, but the very gratifying announcement was made during the evening, that by this effort of the staff of the South-Eastern Railway Company Guy's Hospital had benefited to the extent of £175 (since increased to £235). The result is one of which those upon whom the burden of the work fell may indeed be proud. They must have worked hard, and special thanks and congratulations are due to the honorary secretary, our genial neighbour, Mr. W. Culver, the Station-master at London Bridge, to whose initiative the success of the movement must have been largely due. The occasion was representative of a united effort, from that of the Chairman and Directors of this great Company to that of the lowest paid employee, and Guy's must indeed be grateful while she has such friends to put forth their best energies on her behalf.

A lengthy and varied programme had been arranged by the committee, and the whole was ably managed by Mr. Joseph Turner, Musical Director. The military band having performed a stirring selection, the orchestral band played the overture "Onward," and the troupe marched on. The "Interlocutor" was Mr. Vincer; "Bones" were manipulated by Messrs. Balm, Jacobs, Williams and Hobden; "Tambourines" by Messrs. Broughton, Thomson, White and Hyde. The first part of the programme was composed of ballads and comic songs, of which many were familiar, and several (in spite of the request that no encores be allowed) were re-demanded. Among the most appreciated were: "Home once more," Mr. Tyson; "Silver Moonlight," Mr. Watts; "Did he get there?" Mr. Williams; "For me," Mr. Hobden; "Marguerite," Mr. Vincer; "Whistling Jim," Mr. White; and "Dinah she said yah," Mr. Thomson. The second part of the programme contained a laughable absurdity, "The Wooden-legged Brigade"; Banjo solo, Mr. Richardson; an excellent high pedestal dance, Mr. Wilks, who was vociferously recalled; "Joshuah," whimsically sung by Mr. Hyde; Plantation song and dance, Mr. Lambert; and a clever sketch, "Music and Mystery," Mr. White.

The Banjo band was next in evidence, and then Mr. Hobden received an encore for his rendering of "The Dandy-Coloured Coon." Mr. Marsh gave "The Turkish Patrol" on the concertina, and a lengthy performance was brought to a conclusion with a musical tableau, entitled "Our Friends," a patriotic representation of Britannia, India, Australia, Canada and Africa, which was well received and heartily applauded.

At Guy's Volunteers' Mess.

Passim.

To everyone who takes any interest in us, we wish "A Merry Christmas." To all our contributors during the year, in whatsoever branch, we extend our heartiest thanks, and may the New Year be to the Gazette, and everything connected with Guy's, brighter and more prosperous than the last.

Last year, about this season, the Gazette broke new ground in the distribution with the Christmas Number of a large separate copy of the drawing of our well-known Founder about to sanction plans for the establishment of this Institution. The venture was heralded into existence with anxious hopes, but its success was soon well assured, of which proof in abundance is supplied by the large number of the pictures which are to be seen adorning the said walls of many of our readers' "sancta." So, as everything to succeed in the present day must march with the spirit of the times, we again had to cudgel our addled intellect for some subject worthy to be set before you all in a more extensive and aspiring manner. Before these lines have been perused everyone will have scanned and passed judgment on our present effort, and we can do no more than hope that it may be no less acceptable and interesting than the production of twelve months ago.

In anticipation of a large demand for extra copies, we now give due notice that orders should be sent early to the Librarian, Mr. Mills, accompanied by a remittance of one shilling—postage 1½d. extra.

The excellence of our M.B. London form was fully maintained by our representatives in the B.S., M.D., and M.S. exams. In the former, two Guy's men passed in the first division, and the honours list has not yet been declared. All the candidates from Guy's, Messrs. Leete, Manning and Taylor, gained the M.D. degree, Mr. A. H. Leete obtaining marks qualifying for the gold medal. In the M.S., our only two representatives were successful, and of these, Dr. E. T. Hamilton was one of two qualified to compete for the gold medal, which, for some occult reason, was not awarded.

Our Rugby XV. are to be heartily congratulated on their improved form of late against Kensington and the Old Merchant Taylors. With these results as a criterion more than usual interest should be infused into our match to-day with the London Scottish at Richmond.

At this time of the year one has many things to be thankful for, and we, in pondering over these thoughts, bethought ourselves of our continued obligations to Messrs. Ash & Co., to their spirited manager, Mr. Thos. A. Seabridge, and to all who, under their guidance, labour for us. Each year the work of the Gazette becomes heavier, sleepless nights for "compositor" and "reader" alike become more frequent, and yet we, who scarcely can form an idea of the enormity of their task and of its delicate details, are treated with the same constant courtesy, the same desire to please, and an ardour which in many others could only be called forth by a subject which related to self, and self alone.

At the time of going to press we hear that the Bazaar held in aid of the Sustentation Fund at Dulwich College this week has realised the sum of £126 8s. 11d. This good work was inaugurated and carried out so quietly that the receipt of the money was almost the first intimation that the Hospital received in the matter. We have ascertained, however, that it is to Mrs. Blatherwick, as originator and organiser, energetically assisted by Mrs. Daniell, Mrs. Ray, and Miss Voigt, and other friends, that our best thanks are due.

While on the topic of gifts to Guy's, we cannot forbear to express thanks for a final act of generosity, prompted by the kind heart of the late David James, through whose executors the coffers of Guy's have lately been enriched to the extent of £1,000. Laughter mingled with our tears when from the point of vantage of the pit we viewed this fine actor as the Butterman in "Our Boys," and in many other parts; now, when we find his place vacant, the tears alone rise to our eyes and we are mute.

Much interest has been aroused by the erection of the plate over No. 4 bed, Accident, which announces that the bed is endowed in memory of Henry Alfred Cohen, lost on the Alps, near Reid Villais, Switzerland, July, 1895.

Last Thursday week, the 12th, the Guy's Hospital London University Club gave a grand example of its present flourishing condition,

when the annual dinner was held at the Café Royal. Dr. Savage, presiding over a company of thirty-six, excelled himself in the wit and topicallity of his remarks—would that we had the chance of reproducing some of the gems—and he was ably supported by Drs. Pavy and Dakin and Messrs. F. Durham and C. J. Symonds. The secretaries were able to report an entry of twenty-five members during the year; and the treasurer, Dr. Galton, showed a balance of £28, of which £10 10s. was unanimously voted as a donation to the "Sustentation Fund."

In the compulsory temporary absence of Mr. H. A. Munro from the "path," Guy's, as she always does, has found a champion in one who, till lately, was a stranger amongst us; yet now, after his brilliant performances during the present month with the United Hospitals' Hare and Hounds, Mr. W. L. Baker has climbed several steps of the ladder of fame at Guy's, and we feel sure will, with increased training as the season advances, further enhance his reputation.

We hear that a Ladies' Amateur Banjo and Guitar Troupe will perform in Mary, on Monday, December 30th, at 4 p.m.

We hear that the oratorical efforts at the meeting of the Debating Society—just concluded as we pen these lines, on Thursday evening—were quite up to the usual excellence, and that the subject of "Gambling and Betting" was fought out with great zeal and equality of defence and opposition; in fact, the question was only decided by the casting vote of the President.

It is the Gazette's pleasing duty again to commend to the generosity of all Students the customary Christmas-boxes to all those who during the past year have, in their varying capacities, served us with honesty and goodwill. In the hurry and monotony of our life here, it is perchance easier to grumble at the few wants unattended to than to express gratitude for the many supplied by those around us; therefore, let us, at this season of "Goodwill to all men," give our generosity full play, untramelled by the petty animosities and disputes of our daily routine. Especially let us plead the cause of the Club servants, porters and postmen, from whom we receive many kind acts unasked for, and perhaps occasionally unreciprocated.

From the Separation of Spiritual Heaven and Hell.

A MEMORABLE FANCY. (Not of William Blake's.)

There came unto me the spirit called Ouisqui, and he was dressed in glass, his hat merely cork; and he left his garb so that I could see him no more. Curious his garb was rent in twain in such wise that each half was as a whole. Then came the spirit Ginnrum, who said in my ear, "Engulph me, and shortly will you know the vales of 'Hevan.'" I did so, and then came one with long gown, wooden club and helm; also was he embooted largely—truly it was by his footsteps that I knew 'twas not old Tiriel. Though I was moving rapidly in giddy circles, he, being blind and not seeing that was so, asked me in tones and voice of an antivivisecting stentor to remove myself to other location! Foolish are they that seem as men. . . . With a descendant of Hercules supporting my either arm, we sped on through a maze of argillaceous paste, which seemed as the thinnest air, and I was laid upon a couch of green. As we passed to this haven of rest, I saw that we passed by treble gates which yawed ope their jaws to let us enter; the last gate swung to with a mournful creak, and methought I saw written upon the lintel the legend, "Leave all drink behind, all ye that enter here!" Then did I know that I was in the deathly vale of Guy. Forthwith there came a red and greasy asp, who made straight for my mouth and made me swallow half his length; his tail was dreadful, being expanded as a funnel. Then I heard the rippling of a stream of hellish water and saw the steamy vapours rising from it. . . . How long I lay thus entranced I know not when I heard one in command say: "Come, Battri!" A gossamer of wire appeared, and with it in the air there rose a humming noise as of corn thrashed by a vapoury engine. Then the devils of hell stabbed me with a million pricks and smarts—until I waking saw more clearly my tormentors—who jeered, saying: "Ha, he's coming round." Would that I had ne'er been square! One that hath his acuteness worn by such instruments of hell, becometh truly as a circle. Though knowing it full well they asked me of my name and habitation, which 'twas useless to divulge. Weary of their importunity, I spake them in the language of Euphemia. The humming buzz yet within my ear, Law put his arms around me and saved me from further affliction; wafting me away, along the ground, with tottering steps, ...

[Here the fragment becomes illegible; a little further on the page is torn; a small torn piece is inscribed as follows:—]

"Whisky makes inebriety; batteries sobriety.

"The Road to Drunkenness leadeth to the Palace of Ginn.

"The Crooked Lane from the Palace of Ginn leads to the Temple of Æsculapius." Δ.

A Case of Relapsing Intussusception.

F. R. H., male, æt. 4, was admitted to the Kent and Canterbury Hospital, on July 17th, 1895, in the condition described below. The history of the case is given in the following particulars:—

On July 2nd, Mr. Winter, of Chartham, was consulted on account of patient having passed slime in his motions for two days. There was no constipation or sickness; some slight pains in abdomen, but nothing to be felt. The symptoms all passed off next day under simple treatment.

July 9th. Mr. Winter again consulted about patient. Constant passage of blood and slime for last two days with increasing severe spasmodic attacks of pain in belly. No fæces passed since 6th. Castor oil given on 7th without result; sickness after food. On examination, at 10 a.m., no tenderness of abdomen, no distension or tumour. Given Ol. Ricini ʒ ii.; Tinct. Opii ♏ iv.

4 p.m. No action of bowels; symptoms unaltered; but now a definite sausage-shaped tumour could be felt in the left iliac region. At 11 p.m. I saw patient with Mr. Winter. The invaginated bowel could now be distinctly felt per anum, and on patient straining, the intussusception was seen to protrude externally. Patient was put under the influence of chloroform. He was then taken up by the ankles and inverted while the abdomen was manipulated with the object of restoring the invaginated bowel. Under this treatment the tumour gradually disappeared, and on patient being laid down he passed wind freely and nothing could be felt in rectum. Almost immediately, however, the tumour reappeared, though not so prominently as before. Patient was again inverted and about a pint and a half of hot water slowly injected into rectum by a Higgenson's syringe. Tumour slowly disappeared, and on laying patient down, water was evacuated with considerable amount of fæces. $\frac{1}{10}$ gr. of morphia injected under skin. Patient left quietly asleep.

10th. Tinct. Opii ♏ iii. given at 6 a.m. and repeated at 6 p.m. No pain. Milk only given.

12th. Bowels open; some slime; no blood.

13th. Bowels opened freely; no blood or slime.

14th. Bread and butter given for tea. Got up and went downstairs.

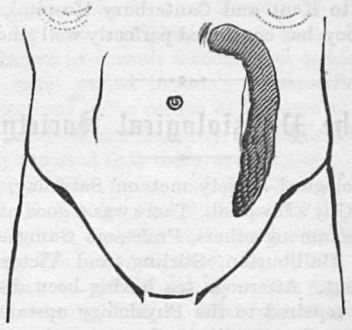
15th. Some pain in abdomen.

16th. Mr. Winter again called in the evening. Tenesmus with passage of blood and slime. Sausage-shaped tumour in abdomen.

17th. Admitted to Kent and Canterbury Hospital.

On admission.—Pale-faced, heavy-looking boy. Temperature 98°; pulse 100. Does not appear very ill. Every half-hour gets sharp attacks of pain in abdomen, making him cry out. Sausage-shaped tumour in left side of abdomen. Abdomen resonant all over, not distended or tender. Urine normal. Heart and lungs healthy. Given Tinct. Belladonnæ ♏ x.; Aq. ad. ʒi., 4tis horis. Diet, Milk Oi, Beef tea Oss.

During day passed blood-stained mucus several times. No sickness. Suppos. Morph. $\frac{1}{6}$ gr., 11.30 p.m.



18th. Condition unchanged, except that pulse is 120 and weaker. Vomited twice during morning. 1.30 p.m.: air injected into rectum by means of the air-pump used for inflating a bicycle pneumatic tyre, which was found to act perfectly. Tumour slowly disappeared. Given Pil. Opii gr. $\frac{1}{4}$ statim; diet continued the same.

19th. No pain; no tumour; no action of bowels. Condition as on 19th until 24th, when bowels acted after an enema, and again by themselves on 25th and 28th.

On August 1st patient ordered minced meat: this he took for dinner on 2nd, and that evening again complained of stomach-ache.

August 3rd. Severe pains at intervals in abdomen. Tumour felt in same position as before, but not so uniform, giving more the impression of scybalous masses. The bowels had not been open for a week. No blood or slime passed per rectum; nothing felt in rectum.

4th. Blood and slime passed; sick. An os-uteri-shaped invagination felt in rectum; carefully examined with a view to feeling any polypus dragging bowel down, but nothing of the sort found. 12 p.m.: air injected into rectum by same means as on 18th July, with same satisfactory result. Diet ordered, milk only, with Tinct. Bellad. ♏x., every four hours.

5th. Patient appeared all right in morning, but symptoms returned in evening.

6th. Again inflated with same results, disappearance of tumour and passage of motion. Diet ordered, milk Oi.; barley water. Bowels opened voluntarily on the 7th, afterwards enema given on 8th, 10th and 13th.

13th. Enema to be given every evening if bowels have not acted.

16th. Tinct. Nucis. Vom. ♏ii.; Tinct. Ferri Perchlor. ♏v.; Aq. Chlorof. ad ʒi. t.d.s. Daily enema continued until September 11th.

On 13th August Beef tea Oss. added to diet.

29th. Fish given for dinner.

September 4th. Baked apples.

13th. Full diet.

After this, the daily enema was discontinued: bowels open every day, sometimes twice, until patient was discharged on September 20th. No further signs of invagination occurred. Parents instructed to pay great

attention to patient's bowels. Mr. Winter, to whom I am indebted for careful notes of the case before admission to Kent and Canterbury Hospital, tells me that the boy has continued perfectly well since.

J. H. J.

The Physiological Society.

The Physiological Society met on Saturday, the 14th instant, at Guy's Hospital. There was a good attendance of members, among others, Professors Gamgee, Burdon Sanderson, Halliburton, Stirling, and Victor Horsley being present. Afternoon tea having been disposed of, the Society repaired to the Physiology upstairs lecture-room to see Dr. Starling's demonstration "On the asserted influence of ligature of the portal lymphatics on the effects of peptone injection." Mr. F. G. Hopkins then showed a new "Method for the separation of pure Urobilin."

In the large lecture-room the following papers were read and discussed:—

A. Gamgee.—(1) "Some new observations which throw light on the nature of Methæmoglobin"; (2) "The relations of Turacin to Hæmatin."

L. Hill exhibited a dog in which both carotids and both vertebral arteries had been ligatured some weeks ago, and which was now recovering.

W. H. R. Rivers gave an account of some experiments and observations he had made on Atropin Micropsia.

J. W. Pickering.—"On the action of poisons on Medusæ."

Dinner was afterwards served in the College reading-room, Professor Gamgee being voted into the chair, and it was pleasant to find that the Steward had produced a really *recherché* repast. After dinner, a vote of thanks to the Guy's Students' Club was carried for their kindness in lending the room and receiving the Society.

R.

He Excuseth Himself.

I'm a poet . . . so they say,
And I know . . .
And (Oh, blow it!) . . .
Write a verse for Xmas Day.

But my feelings are so deep,
Or my muse so fast asleep,
That I cannot sing a lay
Warm enough for Xmas Day.

So I wish for each of you,
Luck in everything you do;
Loss of livers, gain of gold,
Honour, honesty, and old

A. G. E.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Sustentation Fund.

Dear Mr. Editor,—It is as true now as ever it was that "example is better than precept," and it has occurred to me that if every old Guy's man in sending his name as willing to assist in renovating the income of the Hospital, would also send a cheque for a guinea and continue to do so each year, the Hospital would receive by no means a small sum; and the request for a subscription from friends and patients would come with more force and be more likely to succeed.

If every Guy's man puts half the energy that you do into this matter, success would be assured.

Hoping that this suggestion will commend itself to others.—Yours truly,

Tunbridge Wells, December 14th, 1895. EDWIN A. STARLING, M.B.

Philip Ward Concert.

TUESDAY, DECEMBER 31st, 3.45 p.m. to 6 p.m.

Of late years several excellent concerts have at Christmas-time been arranged in Philip through the energy and enterprise of Dr. J. H. Bryant, and for the last two years especial lustre has been shed on such occasions by the valuable and substantial support accorded the promoter by many of those prominent in the theatrical world. All previous efforts were good, but in such affairs each succeeding effort must excel its predecessors.

Last year Mr. Robb Harwood was one of the most energetic and successful artistes, and now, a year later, he is further earning our gratitude by having gathered together a party of ladies and gentlemen whom, for histrionic ability in its varied forms, it would be impossible to excel.

To merely mention them by name is to recall some pleasant evenings spent by each one of us, and these happy recollections ensure that a crowded house will, with gratitude, attempt to repay them for their continued magnanimity and labour in the cause of Charity, where the Theatrical Profession is always to the fore.

The following Ladies and Gentlemen will appear on the present occasion, by kind permission of Miss Nellie Farren, Messrs. George Edwardes, R. D'Oyley Carte, Ernest Oswald, Arthur Bourchier and Fred Kerr:—

Miss Kate Cutler, Opera Comique Theatre
" Ethel Haydon, Gaiety Theatre
" Lena Ashwell
" Florence Perry, Savoy Theatre
" Maggie Roberts, Gaiety Theatre
" Letty Lind, Daly's Theatre
" Kate Phillips, Royalty Theatre
" Kate Tyndall, Opera Comique Theatre

Miss Agnes Hewitt, Princess's Theatre
" Ethel Edwards, Opera Comique
" Clifford, Gaiety Theatre
" Kate Harwood
Mr. Arthur Roberts, Prince of Wales' Theatre
" Eric Lewis, C. P. Little, Farren Soutar, Robb Harwood — Opera Comique
" Fred Storey, Lyceum Theatre
" Arthur Playfair, Terry's Theatre
" Harrison Brockbank, J. J. Dallas — Lyric Theatre
" R. Scott Fishe, Scott Russell — Savoy Theatre
" W. J. Manning, L. Mackinder — Gaiety Theatre
" Alfred Maltby, Duke of York's Theatre
" Charles Ryley, Daly's Theatre
" Robert Pateman, Princess's Theatre
" Oswald Yorke
" J. Furneaux Cook
" Ben Nathan
" J. L. Shine
" Milroy Cooper
" Albert Gilmer
" Horace Gilmer
" Harry Young
The Schartau Glee Quartette
" Stavordale Banjo Quartette

Mr. Robb Harwood has kindly undertaken to stage-manage the entertainment, and the best thanks of all who propose to be present are due to him for the very great interest he has shown and continues to show in the amusement of our patients at Guy's.

The Treasurer's Song.

(With apologies to Lewis Carroll.)

He thought he saw Westralia laid
An offering at his feet;
He looked again and found it was
His yearly balance sheet.
"The word I uttered then," he said,
"I'd better not repeat."

He thought he saw a millionaire
Stroll down the colonnade;
He looked again, and found it was
A pot of marmalade.
"That will not pay our debts," he said,
"I'm very much afraid."

He thought he saw a crocodile
That in an orchard hid;
He looked again and found it was
Five hundred thousand "quid."
"Did I expect all that?" he said,
"Why, certainly, I did."

E. H. C.

The New Conjoint Regulations.

The regulations of the Conjoint Board have always been celebrated for their complexity, and even the Janitor has been known to consult a book when suddenly asked as to the exact period in one's career when it was necessary to "put in" a course of lectures on some out-of-the-way subject like Insanity or Public Health. It is currently reported that there are nine sets of regulations at present in force, and that there is still one chronic at a London hospital under the very old regulations, which are only waiting till he gets qualified to go altogether out of date. It is not, therefore, surprising that we should not have met anyone except Mr. Hallett who understood what was supposed to be going to happen to a man in his later years whose actions were controlled by the regulations for the five years' curriculum issued by the Conjoint Board in January, 1892. There was a general impression that the Conjoint Board had fixed their regulations with unnecessary haste, and had rushed in where the more cautious Universities had feared to tread. At any rate it seemed likely that we should be reading forensic medicine and public health while doing our ordinary ward appointments, and polishing up our clinical medicine and surgery long afterwards in a fever hospital or at a lunatic asylum. Men who were taking the London or Cambridge University course feared it would be impossible to fit in the Conjoint examinations, and were preparing to throw them over altogether. But no one really knew what was going to happen, and the news was greeted with general rejoicing that on November 22nd, 1895, the Conjoint Board had had the courage to alter their elaborate and impracticable regulations, even before some of them had actually been put into force.

So far as we have been able to grasp the effect of these new regulations (which will be found at length in the *British Medical Journal* for December 7th), we are inclined to heartily congratulate the Conjoint Board on the changes they have made. The fact that the London University course is looked upon as a rather formidable undertaking, makes it most desirable that the conjoint course which most London men take as a second string to their bows, should run side by side with it, so that the examinations of the one may be used as stepping-stones to those of the other. The present regulations almost completely meet this requirement, and should encourage a much larger number of men to strive to obtain the London Degree. Another important change is the greater laxity allowed in the proportion of time given to the earlier and later subjects of the curriculum. The industrious man who spends an extra year at anatomy in order to pass his first fellowship, will, under the new regulations, still be able by hard work to obtain a qualification in five years.

The "bones" examination has gone altogether. It originally took the place of an examination in elementary anatomy held at the hospitals, and it is probable that most schools will re-establish such an examination

It will be possible to go up for midwifery a year after passing the Second Conjoint, but, as most men will then be in the full swing of their appointments, it seems doubtful whether they will care to interrupt their studies to take it till just before the other subjects of the final examination. The same is probably true of pharmacology, which can be taken any time after passing the Second Conjoint. Practical pharmacy, which can be studied in the cradle, and passed any time after entering the Hospital, will, it is thought, generally be passed as soon as a man starts work in the wards. At any rate it is well to be able to write a prescription at about that time.

Altogether there is a much more "go-as-you-please" air about the recent regulations, which will be welcomed alike by those who find that examinations provide the necessary stimulus, and by those who agree with the philosopher that they are "organised obstructions to systematic study."

A Song of Degrees.

By an Oriental Student.

(With very necessary apologies.)

M.A., M.B., M.S., M.D.,
You thought enough your wide renown,
To fascinate my simple heart,
Unvers'd in knowledge of the town:
Though mansion fair in Grosvenor Square
Awaits my toil—an English spouse—
Three-figure cheques—a knighthood's rank—
All fail my energies to rouse.

M.A., M.B., M.S., M.D.!
Letters a peer 'd be proud to claim,
Yet insufficient to beguile
One careless of ephemeral fame;
For your sweet sake I would not break
A heart that dotes not on Disease:
A simple maid of dusky Ind
Is worth a thousand d——d degrees!

M.A., M.B., M.S., M.D.,
More plodding pupils you must find;
Were all the Prophet's pleasures yours,
I'd shirk the necessary grind!
You thought 'twould prove a work of love?
My indolence is my reply;
The statue in Guy's ancient court
Is not more cold to you than I.

Trust me, hardly won M.D.!
The Southern sun, here hid from view,
The Orient's luxury and ease,
Smiles at the value set on you!
Whate'er it be, it seems to me
Too much is ask'd of a physician.
Content is more than Harley Street,
And restful ease than vain ambition.

C. M.

Pass List.

University of London, October, 1895.

M.B. EXAMINATION.

EXAMINATION FOR HONOURS.

MEDICINE.

First Class.

Salter, A., obtained the Gold Medal.

Second Class.

Handley, W. S. Harnett, C. J.

Third Class.

Eastes, G. L. Every-Clayton, L. E. V.
Thomas, T. M.

OBSTETRIC MEDICINE.

First Class.

Handley, W. S., obtained the Gold Medal.
Every-Clayton, L. E. V. Salter, A.

Second Class.

Jewell, W. H.

Third Class.

Coleman, J. J. Vellacott, P. N.

FORENSIC MEDICINE.

First Class.

Harnett, C. J., obtained the Scholarship and Gold Medal.
Salter, A.

Second Class.

Eastes, G. L. Hardenberg, E. F. H.
Handley, W. S. Vellacott, P. N.

B.S. EXAMINATION.

First Division.

Chaning-Pearce, D. A. Thomas, T. M.

Second Division.

Every-Clayton, L. E. V. Parry, L. A.
Handley, W. S. Richmond, B. A.
Hora, J. Salter, A.
Jewell, W. H. Steinhaeuser, J. R.

M.D. EXAMINATION, 1895.

Blomfield, E. E. *Leete, A. H.
Hamilton, R. Manning G. E.
Taylor, E. C.

* Obtained the number of marks qualifying for the Gold Medal.

M.S. EXAMINATION.

Hamilton, E. T. E. Sheen, A. W.

University of Oxford, December, 1895.

FINAL EXAMINATION FOR THE DEGREES OF BACHELOR OF MEDICINE AND BACHELOR OF SURGERY.

Panting, L. C.

Appointments.

The following appointments have been recommended by the Medical Council, and approved by the Treasurer:—

Clinical Assistants.—Messrs. W. S. Handley, C. J. Harnett, C. D. Edwards, N. H. Pike, H. T. S. Bell, W. E. Plummer.

Dressers in the Eye Wards.—Messrs. H. P. Ferraby, F. A. Godson (January), C. H. Fagge, C. W. Booker (March) (Mr. Higgens); P. H. Haylett, T. B. Poole (January), P. N. Vellacott, H. A. Moffat (March) (Mr. Brailey).

Surgeons' Dressers.—Messrs. B. Instone, N. Y. Lower, J. Dixon, Edward Evans, F. C. Hitchens, E. H. Pomeroy (Mr. Howse); A. H. Finch, R. Kay, E. J. O'Meara, L. T. A. Rowland, A. M. Rygate, C. Jephcott (Mr. Davies-Colley); R. P. Rowlands, E. I. Spriggs, J. O. Garland, F. G. Thomas, J. T. Roberts, R. Howard (Mr. Lucas); J. Moore, V. E. Collins, G. K. Levick, A. E. Porter, E. F. Clowes, W. A. Fuller (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. H. Cardin, S. H. Mason, M. H. Thornely, W. J. Lindsay, H. Bernard-Onraet, H. Simson, (Mr. Jacobson); J. Ponsonby, F. Golding-Bird, R. J. Rowland, H. Fulton, F. W. Lee, H. R. Marsh (Mr. Symonds); J. G. Watt, A. H. B. Kirkman, J. E. Powell, C. H. Mossop, T. J. Vick, (Mr. Lane); C. R. Hodgson, P. W. Moore, G. N. Mottram, J. B. Walters, C. J. Francis (Mr. Dunn).

Medical Ward Clerks.—Messrs. E. S. Hall, H. W. Allan, W. N. East, Evan Evans, J. H. Jones, R. W. Mayston, H. J. Starling, E. G. Goddard, W. Mussellwhite, A. H. M. Saward, R. T. Fitz-Hugh, W. E. Waymark, F. S. Batchelor, H. D. Peile, A. R. Adams, A. J. Cleveland, A. J. Hull, A. E. B. Crosby, A. C. Ambrose, S. E. Denyer, F. E. Fremantle, F. J. Nicholls, P. Turner, H. J. Barker, H. M. Berncastle, H. W. Bruce, C. L. G. Chapman, R. Fell, C. W. Gibson, F. H. R. Heath, T. H. W. Landon, L. H. Lewis, F. J. H. Martin, G. E. Richmond, C. Shepherd, W. K. Wills.

Assistant Physicians' Clerks.—Messrs. D. B. Todd, G. B. Pearson, C. D. Outred, S. B. Pennington (Dr. Pitt); S. H. Longhurst, W. J. Harvey, A. Kinsey-Morgan (Dr. Shaw); C. C. Poole, W. P. Grellet, A. W. Nourse (Dr. Washbourn).

Aural Surgeons' Dressers.—Messrs. H. A. Munro, W. Tyson (January—February); R. F. Clark, P. C. Prince (March—April).

Dental Surgeons' Dressers.—Messrs. S. G. Graham (January—February); L. G. Reynolds (February—March); A. G. Butler (March—April).

Dressers in the Throat Department.—Messrs. A. J. Sharp, H. W. Beach, J. C. Constable, F. H. Hardy, H. T. Hicks, S. Whicher, W. R. Wood, B. B. Ham.

Post-mortem Clerks.—Messrs. F. J. H. Cann, M. H. Way (January—February); J. Howell, M. C. Hayward (February—March).

Obstetric Ward Clerks.—Messrs. B. P. O'Neill, C. G. Burton, G. E. Duncan.

Obstetric Out-Patients' Clerks.—Messrs. E. T. Scowby, A. T. Falwasser, T. L. Jackson (first half); A. Earnshaw, A. H. Spicer, L. C. Panting (second half).

Surgical Ward Clerks.—Messrs. H. R. Miller, E. C. Davies, H. W. Fox, H. P. W. Barrow, J. Howells, A. D. Lewis, W. T. Milton, J. E. H. Parsons, R. J. Pritchard, H. S. Turner, E. W. S. Rowland, E. H. Musgrove, F. L. Rae.

Assistant Surgeons' Clerks.—Messrs. L. E. C. Handson, H. J. Starling (Mr. Jacobson); A. J. Hull (Mr. Dunn).

Clerks in the Skin Department.—Messrs. T. J. A. Tulk-Hart, C. C. Stead, J. M. Fortescue-Brickdale.

Dental Appointments.

The following Dental Appointments have been recommended by the Dental Council, and approved by the Treasurer:—

Dental House-Surgeons.—Messrs. E. C. Dimock, H. D. Mathews, J. L. Payne.

Assistant Dental House-Surgeon.—Mr. E. R. Tebbitt.

Demonstrators in the Conservation Room.—Messrs. E. C. Brown, J. M. C. Jacobs, E. G. W. Wallis.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

All specimens to be addressed to the Gazette Pathologist, Medical Office.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICES.

C. F. C., Pietermaritzburg.—A section of the nipple and subjacent tissues shows that the ducts and acini of the gland are moderately dilated in consequence of chronic inflammatory changes around the lobules. The sebaceous glands beneath the areola are enlarged. There is no evidence of malignant disease in the specimen.

W. H. M., Kidderminster.—The first portion of the ovarian tumour consisted of a warty growth with a fibrous pedicle. Under the microscope it showed cysts and papillomata lined with columnar epithelium. The cysts were filled with mucoid material. There was no evidence of the growth having invaded the stroma; hence it is very probably not malignant.

W. H. M., Kidderminster.—The second portion of the tumour was almost entirely composed of blood extravasated into a loose connective tissue. A firmer zone on one side of the section appeared to be a remnant of normal ovarian stroma. There was nothing malignant in this specimen.

R. F. R., Lowestoft.—After twenty-four hours' incubation on blood-serum, the resulting growth was found to consist of Klebs-Löffler bacilli associated with small numbers of staphylococci.

A. F., Goadhurst.—No tubercle bacilli could be found in the sputum.

F. E. T., Normanby.—Reaction, acid; sp. gr. 1011 albumen, blood and sugar absent. Microscopic examination of the deposit obtained from the centrifuge shows the presence of large numbers of crystals of calcium oxalate. Squamous epithelium is present in large quantities; also a few granular leucocytes.

G. F. H., Balham.—No tubercle bacilli could be found in the sputum.

G. F. H., Balham.—December 11th.—After twenty hours' incubation on blood-serum the resulting growth was found to consist of the so-called "short" variety of the diphtheria bacillus.

G. F. H., Balham.—December 13th.—After twenty-four hours' incubation on blood-serum the resulting growth was found to consist of the so-called "short" variety of the diphtheria bacillus, associated with various cocci, and long, thick bacilli.

G. F. H., Balham.—December 16th.—After twenty-four hours' incubation on blood-serum, the resulting growth was found to consist entirely of cocci, arranged as streptococci. No Klebs-Löffler baccili could be detected.

G. F. H., Balham.—December 17th.—Neither in the preparations made direct from the brush, nor in those from the growth, which took place on blood-serum, after twenty hours' incubation, could any Klebs-Löffler bacilli be detected. Streptococci only could be seen.

C. W., New Cross Road.—After twenty-four hours' incubation on blood-serum, the resulting growth was found to consist of a few of the so-called "short" variety of the diphtheria bacillus, associated with large numbers of staphylococci.

W. J. H. F., Uttoxeter.—After twenty-four hours' incubation on blood-serum, the resulting growth was found to consist of Klebs-Löffler bacilli in practically pure culture.

J. H. G., Norwood.—The tumour is a sarcoma which has undergone extensive fatty degeneration. It may be called a lipo-sarcoma. We should like to compare this section with the original tumour if that is available for examination.

PATHOLOGIST.

Appointments.

Douglas, W. T. P., M.B. Camb., M.R.C.S., has been re-appointed Honorary Medical Officer to the Children's Cottage Hospital, Cold Ash.

Godson, J. H., M.B., B.C. Camb., has been re-appointed Medical Officer for Cheadle.

Harrison, Philip, has been appointed Demonstrator at the National Dental Hospital.

Kerby, R. J., M.D. Brux., L.R.C.P. Lond., M.R.C.S., has been re-appointed Honorary Medical Officer to the Children's Cottage Hospital, Cold Ash.

Lister, Thos. D., M.D., B.S. Lond., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Westminster General Dispensary.

Morton, A. C., M.R.C.S. Eng., has been re-appointed Medical Officer of Health to North Walsham Urban District Council.

Salter, C. E., M.D., B.S. Lond., F.R.C.S. Eng., has been appointed Honorary Medical Officer to the Scarborough Hospital and Dispensary.

Wacher, Frank, M.R.C.S. Eng., L.S.A., has been re-appointed Medical Officer of Health for the Canterbury Urban District.

Wade, John, B.Sc., has been appointed Lecturer in Chemistry and Physics to the London Society for the Extension of University Teaching.

From the Eye Department.

Old Lady (*loquitur*): "Yes, sir, I was here two years ago, and Mr. Higgens ordered me a pair of asthmatical glasses."

Surgeon (*wishing to know if patient had been "dilated"*): "Have you had a drop in?"

Patient: "Well, doctor, I'll not tell you a lie. I *have* had just a drop or two."

Talking of Eyes, the subtle wit of the Council of the British Medical Association should not be allowed to sink into unmerited oblivion. At the last meeting the Section of Ophthalmology was officially known as "Section I." This is only paralleled by the "Section C.—Salt-water Fish" of (wasn't it?) the "Fisheries"!

Sport.

Association Football.

GUY'S 1st XI. v. THE IDLERS.

Played December 14th. The eleven journeyed to Snaresbrook, and by way of a preliminary training, had a good quarter of an hour's walk to the ground. Our opponents—a likely-looking lot—having lost the toss, started playing down the slight incline. They immediately forced a corner, which, being well-placed, put them one up before we knew where we were, Barker having apparently helped the ball into his own net. From now till the end of the first half, nothing particular occurred (if one excepts some startling decisions of the referee) both goals having some narrow shaves.

At the second half a complete change came over the game; ere a minute had elapsed some neat passing between the right wing and centre enabled Palmer to equalise; then Palmer receiving the ball well up, raced through and scored. Our opponents now had a turn of pressing, but the backs, well assisted by the halves, had no difficulty in repelling them. Ford, receiving the ball from a centre by Mandy, easily put us another goal ahead; and Humphrey, splendidly heading in a well-placed corner by Hall, completed the scoring—our opponents being played almost to a standstill.

The combination of our team was about the best shown this season, Matthews playing a splendid game at centre half, in place of Walker, injured. Our half-back division seems to improve each week. Team:—

Guy's.—H. M. S. Barker (goal); G. Marshall and E. A. Longhurst (backs); R. W. Hall, J. Matthews and H. A. Higgens (half-backs); P. S. Mandy, W. G. Palmer, G. Ford, M. H. Thornely and L. Humphrey (forwards).

GUY'S 2nd XI. v. CARLTON.

These teams met on the Honor Oak ground, on Saturday, December 7th. After an evenly contested game Guy's won by one goal to nil, which was scored during the first half by Camps. During the second half, Carlton looked very much like scoring several times, but always shot too far away from the goal, thus giving the goal-keeper plenty of time to see where the ball was coming. Team:—

Guy's.—A. R. Thomas (goal); J. Matthews, W. H. M. Smith (backs); D. G. Greenfield, H. A. Butler, M. Thornely (half-backs); P. W. Camps, R. G. Edey, E. T. Davies, A. A. Miller, R. M. Barron (forwards).

GUY'S 2nd XI. v. ST. BART.'S 2nd XI.

This match took place at Honor Oak on Wednesday, December 11th, and resulted in a win for Bart.'s by two goals to nil. At the commencement Bart.'s continually pressed, but failed to score. Guy's, after a time, appeared to wake up more, and, led by Palmer and Ford, looked like scoring, but failed to do so. Soon after this the saints scored their first goal. After changing ends, Lavers went in goal, and the game was of a more even description and faster than it had been in the first half. Bart.'s looked like scoring once from a corner kick, but the ball was cleverly fisted away by Lavers, and, when they did score their second goal, Lavers succeeded in keeping the ball out of the net twice, but was beaten the third time. The forwards were a bit slow in getting away when they got the ball, Ford not playing up to his usual form. During nearly the whole of the first half we were playing one man short. Team:—

Guy's.—A. R. Thomas (goal); J. Matthews, N. Lavers (backs); D. G. Greenfield, H. A. Butler, C. Fowke (half-backs); P. W. Camps, L. Humphrey, G. Ford, W. G. Palmer, R. M. Barron (forwards).

GUY'S 2nd XI. v. CLAPHAM ROVERS.

Played at Honor Oak, on Saturday, December 14th. On starting the ball Guy's immediately pressed, but were unable to put the ball between the posts. After various shots Kempe scored the first goal for Guy's from a corner kick. Soon afterwards Davies kicked the second goal. Nothing more happened before the whistle sounded for half-time, when Guy's were still pressing.

On changing ends, the Rovers played up better, but never looked at all dangerous, and Guy's soon had matters their own way again, scoring two more goals before the call of time, which were kicked by Barron and Kempe. The forwards played well together, especially noticeable being Davies and Kempe. Team:—

Guy's.—A. R. Thomas (goal); S. Smith, W. H. M. Smith (backs); D. G. Greenfield, H. A. Butler, A. M. Miles (half-backs); R. M. Barron, S. Nash, E. T. Davies, A. M. Kempe, P. W. Camps (forwards).

Rugby Football.

GUY'S 1st XV. v. OLD MERCHANT TAYLORS.

These teams met at Honor Oak Park, on Saturday, December 7th, the result being a pointless draw, neither side scoring. The game throughout was confined to the front rank, the backs on either side having few opportunities. The Hospital forwards played a good game, and showed themselves quite a match for the Taylors, but they have still to learn to break away quickly when they get the ball amongst the back rows of the scrum.

GUY'S 1st XV. v. THE ROYAL ENGINEERS.

This new fixture was played at Chatham on Wednesday, December 11th, but, unfortunately (owing to the weather) was not a success. The dense fog in London upsetting all the train services caused us to be very late in putting in an appearance, and consequently we had to be content with playing a quarter of an hour each way.

The game, moreover, was of a very scratchy character and uninteresting all through, resulting in another draw —the fifth we have played this season.

GUY'S 1st XV. v. KENSINGTON.

Honor Oak Park was the venue of this match on Saturday, December 14th, and resulted in a good win for the Hospital by one goal and two tries to nil. The game was started soon after the advertised time, Goddard kicking off for the Hospital, who at once began to force matters. Within two minutes, Dykes, from some loose play in the visitors' territory, dribbled over the line, and scored the first try, which was unconverted. Kensington re-started, and Alexander returned, the opposing full back muffing the ball; Dykes, following up quickly dribbled past him, and, picking up the ball, scored the second try, which was again unconverted. On re-starting, a series of scrums ensued, Kensington being awarded a free kick for off side; the ball was again carried into the Hospital twenty-five, where Ransford was called upon to save a rush of the opposing forwards, nothing further being scored up to half-time.

Kensington, at the commencement of the second half, played up much harder, and kept the ball for several minutes in the home twenty-five, but were unable to score, a rush of the Hospital forwards at last relieving, the ball being carried to mid-field, when, from a pass out from Bryant, Alexander scored for the Hospital between the posts, the try being easily converted into the major point. Nothing further was scored, the Hospital being disallowed a try gained by Hunter, owing to a misunderstanding between the referee and linesman, the Hospital winning as mentioned above.

For the Hospital, Dykes, Gwynn and Rashleigh played a splendid game forward, whilst J. H. Bryant was a great acquisition at half-back, and only helped to show how badly we lack a good half-back in the regular team.

United Hospitals' Hare & Hounds.

UNITED HOSPITALS' HARE AND HOUNDS v. THAMES HARE AND HOUNDS.

A contest between the above clubs took place on Saturday, December 7th, over a 7¾ miles' course at Roehampton. A close finish ended in favour of the former by the narrow margin of one point, this being the Hospitals' first race and win this season. E. H. Flack beat his club member, A. L. Rye, after a good race, by twelve yards, W. L. Baker, of Guy's, being third, two yards separating second and third. A. G. Butler ran well but disappointingly, as he was generally looked upon as the probable winner. The order of finishing was as follows:—

1.	E. H. Flack (T. H. & H.) ...	50	min.	25	sec.
2.	A. L. Rye (T. H. & H.)	50	„	28	„
3.	W. L. Baker (U. H. H. & H.) ...	50	„	29	„
4.	A. G. Butler (U. H. H. & H.) ...	50	„	56	„
5.	C. Watson (U. H. H. & H.) ...	51	„	38	„
6.	F. G. Rye (T. H. & H.)	52	min.	—	sec.
7.	F. E. Fremantle (U. H. H. & H.)	52	„	50	„
8.	G. R. Elwin (U. H. H. & H.) ...	54	„	22	„
	F. W. Chandler (U. H. H. & H.)	54	„	29	„
9.	J. J. Franco (T. H. & H.) ...	54	„	58	„
	R. Balderston (U. H. H. & H.) ...	55	„	24	„
	P. G. Mould (U. H. H. & H.) ...	55	„	25	„
	A. F. Page (U. H. H. & H.) ...	56	„	15	„
10.	T. B. Hennell (T. H. & H.) ...	57	„	54	„

Also competed: R. Howard, G. E. Mould, G. G. Davidson (Hospitals), and J. E. Dixon (Thames).

The first five on each side being counted, the result was:—

Hospitals 3+4+5+7+8=27 points.
Thames 1+2+6+9+10=28 points.

The Guy's men were well to the fore in W. L. Baker, C. Watson and F. E. Fremantle, who will probably do better performances later in the season. R. B.

UNITED HOSPITALS HARE AND HOUNDS INVITATION RACE.

The Hospitals' handicap race took place on Saturday, December 14th, at Chingford, over a course the distance whereof is five miles two hundred yards. Included in the field was J. M. Fremantle (Hertford College), the Oxford Fresher, who ran from scratch and won in the record time of 29 min. 5 sec., thus defeating all previous records held by H. A. Munro, H. Wade or F. A. Cohen. For this fine performance a special fast time medal was awarded to him. W. L. Baker (Guy's), as was expected, ran splendidly, gaining the first prize, and also the Club fast-time medal in the good time of 33 min. 55 sec., H. A. Munro's best time being 30 min. 48 sec. The finish was as follows:—

		Start. m. s.	Handicap Time. m. s.	Net Time. m. s.
—	J. M. Freemantle (Lea H.)	—	29 5	29 5
1.	W. L. Baker (Guy's) ...	0 40	30 15	30 55
2.	F. G. Rye (T. H. & H.) ...	1 20	30 25	31 45
3.	F. E. Fremantle (Guy's) ...	1 30	30 43	32 13
4.	F. Barfield (Lea H.) ...	1 20	30 47	32 7
5.	P. G. Mould (St. Mary's) ...	2 10	30 49	32 59

Also ran:—G. E. Mould (St. Mary's). G. J. Brassey (Lea H.), W. E. Ruttledge (University Coll.), R. Howard (Guy's), W. H. Midwinter (T. H. & H.), A. D. Hood (Lea H.), A. Ormond (Guy's), E. H. Flack (T. H. & H.), A. L. Rye (T. H. & H.), H. Page (Bart.'s), C. Watson (Guy's), C. V. Cornish and S. R. Scott (Bart.'s), C. S. Dunlop and D. L. Davis (University Coll.), E. H. T. Markham (H. C. H. & H.). R. B.

Marriage.

WINGATE — SOPER. — On December 7th, at St. Andrew's Church, Ashley Place, Westminster, William Warburton Wingate, M.B., B.C. Camb., eldest son of the late William Wingate, of Ludford Magna, Lincs., to Isabel Mary, daughter of William Soper, M.R.C.S. Eng., of Clapham Road.